

160652

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 7 8 5

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
BETTY LOUISE ADAMS					May 31, 1985					8:40 PM	
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 2 YEARS		
Female	White	Dec. 5, 1934			50 YRS		MONTHS DAYS		HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	USA				Allegany MD						
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
Cumberland	Memorial				Secretary		Finance Co.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE	13b COUNTY	13c CITY OR TOWN		13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE						
MD	Allegany	Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	214 North Lee Street 21502						
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Samuel J. Martin				Isabelle Jenkins							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
No		579-46-7643		Robert J. Adams		Husband Cumberland Maryland					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced heart cell Ar. Inf.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>February</u> , 19 <u>85</u> , to <u>May 31</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>May 31</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Zaman				22e ADDRESS 500 Memorial Ave., Memorial Medical Bldg., Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		6-3-85		Rosedale Funeral Ch.		Martinsburg Berkeley WV					
24 FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Scarpelli Funeral Home				Cumberland, MD 21502		JUN 05 1985		<u>[Signature]</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

100025

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

SCARPELLI FUNERAL HOME				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 5 1 2 7 8 6	
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRA NMI ALLMAN				2a. DATE OF DEATH MONTH DAY YEAR MAY 27 1985		2b. HOUR 12:00 PM	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 07-18-1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Operating engineers	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Allman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Carrico		13e. STREET ADDRESS / ZIP CODE 1123 Bedford Street/21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 232-22-4912		17. INFORMANT ADDRESS Mrs. Ramonia Allman, Cumberland, MD - wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of unknown primary</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>unknown primary</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u> <u>7 ga</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Obstructive Pulmonary Disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE SLIDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/29/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>[Signature]</u>		22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05-31-1985		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE JUN 04 1985 <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked as item 18 showing injury, or other traumatic event, the medical examiner must be notified.

100-431

YOUNG MANUSCRIPTS

158090

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 / 8 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST GRETCHEN M. AMICK			MONTH DAY YEAR MAY 28, 1985			4:33A M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female	White	MONTH DAY YEAR March 30, 1908		76 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
W. Va.	U.S.			Allegany MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND	MEMORIAL HOSPITAL		Nurse			Hospital		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Pa.	Bedford	Bedford	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Pennknoll Village 99999			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST George W. Morey		FIRST MIDDLE LAST Grace Wotring						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No		235-14-6188		Ann Whitmore 137 Palma Del Rio Las Vegas, Nev.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY								
IMMEDIATE CAUSE (a) <u>Renal failure.</u>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
(b) <u>chronic glomerulonephritis</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Organic brain syndrome, Acute peritonitis.</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. ALTOPS?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
			HOUR A.M. MONTH DAY YEAR P.M. 19					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost <u>saw the deceased alive</u> above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<u>Ranjithan</u>			MD			5/28/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. MEMORIAL HOSPITAL			CUMBERLAND,		
DR. RANJITHAN			MEDICAL BUILDING			MARYLAND 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial			May 30, 1985		Maplewood Cemetery		CITY OR TOWN COUNTY STATE Kingwood, Preston W. Va.	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
<u>John K. Whitehair</u>			Terra Alta, W. Va.			JUN 03 1985 <u>John K. Whitehair</u>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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141045

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

1 2 / 8 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Hannah Mary Anastasia			2a. DATE OF DEATH MONTH DAY YEAR 05/10/85		2b. HOUR 6:45 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 20, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cumberland Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper	12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Allegany 13c. CITY OR TOWN Cresaptown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 12999 Sixth Ave./21502	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Morgan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minerva Mackey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 569-52-0195		17. INFORMANT ADDRESS Mrs. Elaine Brauer - Cresaptown, MD	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CVA.			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 85	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/10 19 85 , to 5/10 19 85 , that (I) (we) last saw the deceased alive on 5/10 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE P. HALMOS	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/11/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. HALMOS		22e. ADDRESS 302 Schleight, Cumberland, Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 14, 1985	23c. NAME OF CEMETERY OR CREMATORY Penn-Lincoln Mem.	23d. LOCATION CITY OR TOWN COUNTY STATE N. Huntingdon, Westmoreland, PA
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.		ADDRESS LaVale, MD	25a. DATE REC'D. BY REGISTRAR MAY 16 1985
		25b. REGISTRAR'S SIGNATURE Jane Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner who has the medical authority to sign this certificate must be notified.

140118

F

David A. Burdock FH
1- STATE REGISTRAR
Kitzmilller, MD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 7 8 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles Bantz Aronhalt			2a. DATE OF DEATH MONTH DAY YEAR May 10, 1985		2b. HOUR 9:45pm	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 8 1919		
6. AGE (IN YEARS LAST BIRTHDAY) 65		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mt. Storm		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS		
9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD		10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W.Va		13b. COUNTY Mineral		13c. CITY OR TOWN Elk Garden		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 1		13f. ZIP CODE 99999		
14. FATHER'S NAME FIRST MIDDLE LAST Edward Aronhalt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Kitzmilller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS David A. Burdock Kitzmilller, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) probable myocardial insufficiency						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5-5 19 85 to 5-10 19 85 , that (I) (we) last saw the deceased alive on 5-11 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.						
22b. SIGNATURE Donald A. Manger		DEGREE MD		22c. DATE SIGNED 5-11-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald Manger, M.D.		22e. ADDRESS 55 Jackson Street, Lonaconing, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-13-85		23c. NAME OF CEMETERY OR CREMATORY Mt. Storm Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Storm Grant W.Va		23e. DATE REC'D. BY REGISTRAR MAY 16 1985				
24. FUNERAL DIRECTOR NAME David A. Burdock		24b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

David A. Smith, M.D.

Stamford, CT

Charles Smith, M.D.

May 10, 1962

2-445

Allegany County

Stamford Hospital

250-2-3048

55 Jackson Street, Farmington, CT

Donald Smith, M.D.

157109

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

12790

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Carl Leroy Atkinson			2a. DATE OF DEATH MONTH DAY YEAR 5 / 1 / 85		2b. HOUR 2:25 P. M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 24, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Frostburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tire Builder		12b. KIND OF BUSINESS OR INDUSTRY Tire Co.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Frostburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Paul Atkinson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Robinson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-16-4420		17. INFORMANT ADDRESS Mrs. Donna Lewis, Same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung w/ metastasis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/1/85 19 85 , to 5/1/85 19 85 , that (I) (we) last saw the deceased alive on 5/1/85 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Angel Roque M.D.		DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Angel Roque, M.D.		22e. ADDRESS 48 Broadway, Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 22 '85		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Wash., Md.		24. FUNERAL DIRECTOR NAME ADDRESS Durst Funeral Home, Frostburg, Md.			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE MAY 20 1985			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified to examine the body.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

148134

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

1 2 7 9 1

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) EDITH ROSEMONT ATKINSON			2a DATE OF DEATH MONTH DAY YEAR May 20, 1985		2b HOUR 7:40 PM	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR June 4, 1902		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.		
10 CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Allegany	13c CITY OR TOWN Cumberland		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST William Wilkins			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara College			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-26-9871		17 INFORMANT ADDRESS Alice Isner, daughter 502 Sheridan St. Cumberland, MD		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebrovascular atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days year						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (1) this hospital attended the deceased from 5-6 , 19 85 , to 5-20 , 19 85 , that (1) (we) last saw the deceased alive on 5-20 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.						
22b SIGNATURE Dr. Bollino		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 2/2/85
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Bollino		22e ADDRESS 955 Frederick St. Cumberland, MD 21502				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 5/23/85	23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Cumberland Alleg. MD	
24 FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home, Inc.		25a DATE REC'D. BY REGISTRAR MAY 24 1985				
25b REGISTRAR'S SIGNATURE John W. Anderson		25c REGISTRAR'S SIGNATURE John W. Anderson				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Clarence		MIDDLE Barton		LAST Barton		2a. DATE KNOWN OF DEATH ESTI. MATED		MONTH 5		DAY 22		YEAR 1985		7b. HOUR 8:59 AM	
3. SEX Male	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 7 9 1917		6. AGE (IN YEARS) (LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 22 1985		2d. HOUR 8:59 AM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD											
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter				12b. KIND OF BUSINESS OR INDUSTRY construction							
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE W. VA.		13b. COUNTY Mineral		13c. CITY OR TOWN Ft. Ashby		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS FT. Ashby Road 99999									
14. FATHER'S NAME FIRST MIDDLE LAST John Barton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine				16. ADDRESS Cumberland, MD									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 214-07-3845				17. INFORMANT Mrs. Carolyn Ternewit 309 Bourbon St. 21502									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.S.C.U.D.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE Francisco Reyes				TITLE (SPECIFY) Deputy				M.D. MEDICAL EXAMINER				DATE SIGNED 5-22-85					
EXAMINER'S NAME (TYPE OR PRINT) Francisco Reyes				ADDRESS 900 Seton Dr. Cumberland Md													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 24, 1985				23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE LaVale Allegany MD 21502					
24. FUNERAL DIRECTOR NAME Anthony J. Eichhorn				ADDRESS 8 E. MAIN ST. Eichhorn Funeral Home, Lonaconing, MD				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE J. R. Riddle					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1. PAGES 1, 2, AND 3 SHOULD BE KEPT IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

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(VRA 15, 4)

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FOR
STATE REGISTRAR
SCARPELLI F.H. FOR
JOHN C. MILLER F.H.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 7 9 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GLADYS NMI BAUMILLER			2a. DATE OF DEATH MONTH DAY YEAR 05-31-85		2b. HOUR 8:50 A.M.	
3 SEX Fem.	4. RACE Cau.	5. DATE OF BIRTH MONTH DAY YEAR 12 29 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NAMED, GIVE FULL ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Md.	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 60 Hilltop Rd. 21052		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Zizwark		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 212-22-2991		17. INFORMANT ADDRESS William J. Baumiller 60 Hilltop Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Ca Stomach DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Alzheimer's Disease						
19a. DATE OF OPERATION 5/31/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on 5/31/85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Spiggle MD		DEGREE MD		22c. DATE SIGNED 5/31/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WAYNE C. SPIGGLE, M.D.		22e. ADDRESS 912 SETON DRIVE, CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6-3-85	23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Perry Hall Balto. Md.		
24. FUNERAL DIRECTOR NAME John C. Miller Inc. 6415 Belair Rd.		ADDRESS 6415 Belair Rd.		25a. DATE REC'D. BY REGISTRAR JUN 4 1985		
		25b. REGISTRAR'S SIGNATURE John Davidson-Hendall				

127098

SCARBOROUGH T. BAY
WATER C. BRIDGE N.B.
BALTIMORE, MD.
CLAY'S



1000 A.M.

02-21-92

WATER C.

ALLGAIN EXPT. CO.

SACRED HEART HOSPITAL



WATER C. BRIDGE N.B.
BALTIMORE, MD.

ALLGAIN EXPT. CO.

WATER C. BRIDGE N.B.

149094

SCARPELLI FUNERAL HOME 1 - STATE REGISTRAR 108 VIRGINIA AVE. CUMBERLAND, MD 21502				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 5 1 2 7 9 4			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
EDWARD OWEN BEASLEY				MAY 18, 1985				5:45 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 72 HRS	
male		white		05-28-1913		71 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
VA		USA				ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		SACRED HEART HOSPITAL				Retired Millwright		Local Millwright			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MD				Allegany		LaVale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6 Campground Road/21502	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Heath Beasley				Johanna Cochran							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no				224-03-4320		Mrs. Nellie R. Beasley, LaVale, MD - wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE LUNG</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>				DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-18-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
SUSAN F. SCHUBERTZ, MD				RT. 5 36 & 40, FROSTBURG PLAZA, FROSTBURG, MD 21532							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				05-21-1985		St. Mary's Cemetery		Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, MD 21502								<i>[Signature]</i>			

MAY 24 1985

1-20-00

SCARPELLI FUNERAL HOME
101 VIRGINIA AVE.
CRASTLAND, MD 21112

EDWARD CARDEN

MAY 12, 1982

5:12 A.M.

ALLEGANY COUNTY

SACRED HEART HOSPITAL

228-03-1520

AT 2 26 2 40, PROTESTING DAY, PROTESTING
MD 21112

1530889

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

1 2 7 9 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALVIN GEORGE BEEMAN			2a. DATE OF DEATH MONTH DAY YEAR MAY 29, 1985			2b. HOUR 1:31A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 9 1928		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Kelly		12b. KIND OF BUSINESS OR INDUSTRY Tire	
13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Barton	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE Rt. 1 box 307 21521			
14. FATHER'S NAME FIRST MIDDLE LAST Howard A. Beeman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Marie Garlitz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11 220-24-7542		17. INFORMANT ADDRESS Mrs. Emogene Beeman Barton, Md. 21521			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sepsis, perforated colon DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal failure, liver failure DUE TO, OR AS A CONSEQUENCE OF (c) Pre-existing ASCVD & CAD & CHF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASCVD							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/7 19 85 to 5/28 19 85 , that (I) (we) last saw the deceased alive on 5/28 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thaddeus Elder				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. THADDEUS ELDER				22e. Memorial Hospital Cumberland, Medical Building Maryland 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/1/85		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Barton Allegany a Maryland	
24. FUNERAL DIRECTOR NAME Boals Funeral Service Westernport, Md.				25a. DATE REC'D. BY REGISTRAR JUN 03 1985			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if there is any injury, or other traumatic event, the medical examiner must be notified.

BP

esostat

136011

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

12796

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD MERLE BENDER			2a. DATE OF DEATH MONTH DAY YEAR May 8, 1985		2b. HOUR 6:45a.m.
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 05-23-1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired	12b. KIND OF BUSINESS OR INDUSTRY Meat Processing
13a. STATE MD					
13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Bender			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alpha Crabtree		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II		17. INFORMANT ADDRESS Mrs. Margaret L. Bender, Cumberland, MD-wife	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) CVA -				80 DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD -	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD - Severe				years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 05/1 19 85 , to 5/8 19 85 , that (1) (we) lost saw the deceased above (1) (we) (did) (and) not view the body after death. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James Raver				22c. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05-10-1985		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	
23d. LOCATION (CITY OR TOWN) Cumberland		23e. COUNTY Allegany		23f. STATE MD	
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRY MAY 14 1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

100% COTTON

MADE IN U.S.A.



12797

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
BERTHA		MILDRED		BOGGS		MAY 13, 1985		1:30P.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
female		white		10-25-1910		74 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS.	
PA		USA				Allegany		MD	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL & MEDICAL CENTER		retired presser		Laundry			
14a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		14b. STATE		14c. COUNTY		14d. CITY OR TOWN		14e. INSIDE CITY LIMITS?	
MD		Allegany		Cumberland		YES <input type="checkbox"/> NO <input type="checkbox"/>		14f. STREET ADDRESS / ZIP CODE	
15. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		15. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		15. FATHER'S NAME	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		FIRST MIDDLE LAST		FIRST MIDDLE LAST		FIRST MIDDLE LAST	
Valentine Wertz		Arrena T. Bennett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		17. ADDRESS			
no		213-22-4425		Goldie M. Lewis, Greenspring, WV-sister					
18. CAUSE OF DEATH (Enter only one cause per line. Do not include conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)		18. CAUSE OF DEATH (Enter only one cause per line. Do not include conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)		18. CAUSE OF DEATH (Enter only one cause per line. Do not include conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)		18. CAUSE OF DEATH (Enter only one cause per line. Do not include conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)		18. CAUSE OF DEATH (Enter only one cause per line. Do not include conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)	
PART 1: DEATH WAS CAUSED BY:		PART 1: DEATH WAS CAUSED BY:		PART 1: DEATH WAS CAUSED BY:		PART 1: DEATH WAS CAUSED BY:		PART 1: DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) and (we) the deceased (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

CONF. CO. 100M

RECEIVED

143141

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 / 9 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WENDELL R. BOGGS			2a. DATE OF DEATH MONTH DAY YEAR May 16, 1985			2b. HOUR 3:57 A.M.			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 09-26-1924		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret. Sgt. Major		12b. KIND OF BUSINESS OR INDUSTRY Marine Corp	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 643 Hilltop Drive/21502	
14. FATHER'S NAME FIRST MIDDLE LAST Guy Boggs				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Bean					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 220-16-6676		17. INFORMANT ADDRESS Mrs. Margaret Boggs, Cumberland, MD - wife					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) MI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ASCD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Concussion x 2 + cerebral aneurysm									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/10/85 19 to 5/16/85 19, that (I) (we) last saw the deceased alive on 5/15 19, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 16 May 85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Anthony Bollino					22e. ADDRESS 955 Frederick Street Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 05-18-1985		23c. NAME OF CEMETERY OR CREMATORY Rocky Gap VA Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Flintstone Allegany MD		
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502					25a. DATE REC'D. BY REGISTRAR MAY 20 1985		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

1960



200 CASH 1.16.0
B. L. F. M. 1.16.0

158033

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Gerald Michael Broderick			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 27 1985			2b. HOUR M		
3. SEX Male	4. RACE Cau	5. DATE OF BIRTH MONTH DAY YEAR 07-29-1910	6. AGE (IN YEARS) (LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 27 1985		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 537 Bishop Walsh Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY County Roads
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21502 Apt 7 537 Bishop Walsh Drive		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Broderick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Robeson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				
16b. SOCIAL SECURITY NO. 217-10-5258		17. INFORMANT ADDRESS Mrs. Larue C. Broderick, Cumberland, MD						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b). Coronary artery heart disease DUE TO, OR AS A CONSEQUENCE OF (c).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden Years
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

Post-operative repair, fractured left hip 20 days

19a. DATE OF OPERATION 5 7 85	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fractured left hip	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH A.M. xx 5 7 1985	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5 7 1985	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Patient fell at home
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK At home	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) At home	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 537 Bishop Walsh Drive Cumberland Alleg. Md

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE <i>Paul Snow</i>	TITLE (SPECIFY) M.D. Dpty	MEDICAL EXAMINER Memorial HOspital	DATE SIGNED 5-27-85
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D.		ADDRESS Memorial HOspital	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 05-29-1985	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 31 1985	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (15))

12003



WILLIAMSON

1 FEB 11 1903

12003

143023

LEASURE- STEIN FUNERAL HOME STATE OF MARYLAND
 230 BALTIMORE STREET DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CUMBERLAND, MD 21502 CERTIFICATE OF DEATH

85

12800

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
GEORGIE RAMONA BULLETT				MAY 15, 1985		12:05 P	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Female	Black	June 2 1928		56 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	USA			ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland	SACRED HEART HOSPITAL		Housewife		Home		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE			
Maryland	Allegany	Cumberland		944 Gay St. 21502			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		ADDRESS			
Douglas --- Waites		Mary --- Green		Cumberland, Md. 21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		215-56-7710		Angelina Willis 944 Gay St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia & septic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>shock</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cardiac Artery Thrombosis</u> <u>COPD</u> <u>S/P CVA</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> <u>5/10</u> <u>1985</u> to <u>5/15</u> <u>1985</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>R Espina</u> DEGREE <u>MD</u>		22c. DATE SIGNED <u>5/15/85</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
RENATO ESPINA, MD		22e. ADDRESS		907 SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		5/18/85		Woodlawn Cemetery		Cumberland Allegany Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Cumberland, Md. 21502		MAY 20 1985		<u>J. Davidson</u>			
Leasure-Stein F. Home 230 Baltimore Ave.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

143053

LEASER-STEIN FURNAL HSE
330 BALTIMORE STREET
CAMDEN, MD 21602

GEORGE RAYMOND
MAY 15, 1982
13:00 P

ALLEGANY COUNTY

SACRED HEART HOSPITAL

315-26-3710

ADMINISTRATIVE

205 EIGHTH DRIVE, CAMDEN, MD 21602
PRIVATE ESTATE, MD

MAY 21 1982

158009

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

1 2 8 0 1

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Angus L. Campbell			2a. DATE OF DEATH MONTH DAY YEAR 5 24 85 2b. HOUR 2:50 P.M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 15 36	6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.		
10. CITY OR TOWN OF DEATH Frostburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSTRUCTION		12b. USUAL BUSINESS OR INDUSTRY LOCAL HELPER
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Mt. Savage	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS BOX 11A RT. 1 MT. SAVAGE 21545	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES E. CAMPBELL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA HOENSHALL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 1954	16b. SOCIAL SECURITY NO. 1956	17. INFORMANT ADDRESS 21536 MR. HARRY CAMPBELL, GRANTSVILLE, MD			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASPIRATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>UPPER GASTROINTESTINAL BLEEDING</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ADVANCE LIVER CIRRHOSIS, ACUTE ALCOHOL HEPATITIS</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK NOT AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 20</u> , 19 <u>85</u> , to <u>MAY 24</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>MAY 24</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>S. Chang M.D.</u>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Saturnina Chang, M.D.		22e. ADDRESS Heck's Plaza Frostburg, MD 21532			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL	5/26/85	MT. SAVAGE, MONTGOMERY	MT. SAVAGE, ALLEGANY MD		
24. FUNERAL HOME SOWERS FUNERAL HOME FROSTBURG					
25. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 23 1985					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

120003



U.S. AIR FORCE
OFFICE OF THE
JOINT CHIEFS OF STAFF
WASHINGTON, D.C.
20330
MEMORANDUM
SUBJECT: [Illegible]
DATE: [Illegible]
TO: [Illegible]
FROM: [Illegible]
[Illegible text follows, including various administrative markings and stamps.]



RECEIVED
[Illegible text]

140112

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTI- MATED			MONTH DAY YEAR			2b. HOUR			
CORTEZ WILSON CHILDRESS						5 13 85									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		Cau		2 2 23		62						5 13 85		2115	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
VA				USA								Allegany			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS)				12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland				717 Maryland Avenue				male retired nurse				hospital			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Maryland				Allegany				Cumberland				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.			
Roy F. Childress				Mary Lou Franklin				no				226-18-8964			
17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			
Mrs. Laura M. Logan, Cumberland, MD				PART I DEATH WAS CAUSED BY:											
				IMMEDIATE CAUSE (a) Cardiac arrest								20. AUTOPSY?			
				Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				DUE TO, OR AS A CONSEQUENCE OF											
				(b) Arteriosclerotic heart disease											
				DUE TO, OR AS A CONSEQUENCE OF											
				(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
Diabetes; chronic alcohol abuse															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
								STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Paul Snow				M.D. Ast Dpty				5 14 85							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Paul Snow, M.D.				Memorial Hospital											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				05-16-1985				Sunset Memorial Park				Cumberland Allegany MD			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
James F. Scarpelli, Cumberland, MD 21502				MAY 16 1985				Julia Davidson-Randall							

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

140313

2023 COLLECTION 2003

Allegany

Chesapeake

Allegany Chesapeake



United States

Allegany/Chesapeake

Chesapeake; chronic alcohol abuse

Allegany

Chesapeake

129563

FOR STATE REGISTRAR
GEORGE & UPCHURCH
202 GREEN STREET
CUMBERLAND, MD. 21502

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 5 1 2 8 0 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ORTHA WERT CLARK			2a. DATE OF DEATH MAY 4, 1985		2b. HOUR 02:30 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 16, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sewing Mach. Oper.		12b. KIND OF BUSINESS OR INDUSTRY Garment Factory
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 34 Yoder St. 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Floyd Holmes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene Sansom			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 203-12-1436		17. INFORMANT ADDRESS Chinelsa Henderickson, 36 Yoder Dr. Cresaptown 21502	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIC - shock - Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent Fluorid bloods - IVC Phlebitis DUE TO, OR AS A CONSEQUENCE OF (c) Tumor of the lung Probably Cancer. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 5/3 19 85 to 5/4 19 85 , that (I) (we) last saw the deceased alive on 5/3 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE		22c. DATE SIGNED 5/6/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. V. RAUL FELIPA, M.D.		22e. ADDRESS 925 BISHOP WALSH RD., CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/6/85	23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME Wendy N. Upchurch ADDRESS Cumb., MD		25a. DATE REC'D. BY REGISTRAR MAY 7 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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(6)

UNITED STATES
DEPARTMENT OF
COMMERCE

OFFICE OF THE
SECRETARY
WASHINGTON, D. C.

MINISTER OF COMMERCE

DEPARTMENT OF COMMERCE

DEPARTMENT OF COMMERCE

DEPARTMENT OF COMMERCE
WASHINGTON, D. C.

DEPARTMENT OF COMMERCE
WASHINGTON, D. C.

DEPARTMENT OF COMMERCE
WASHINGTON, D. C.

160097

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 0 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	MONTH	DAY	YEAR
George Richard Clayton			5 30 85			17:11 pm		
3. SEX			4. RACE			5. DATE OF BIRTH		
male			cau			MONTH DAY YEAR 9 28 33		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
Maryland			USA			9. BALTIMORE CITY OR COUNTY OF DEATH		
Cumberland			Sacred Heart Hosp.			Alleg. MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Cumberland			Sacred Heart Hosp.			(None)		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Alleg.			Cumberland		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES		
Theodore J. Clayton			Amelia Irene Grant			yes 1953		
16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>year</u>		
218300082			Amelia I. Clayton-Address same as #13 above.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>5/30</u> 19 <u>85</u> , to <u>5/30</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>5/30</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
R. Espina, M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			5/30/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
R. Espina, M.D.			907 Seton Drive-Cumberland, Maryland			21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			6-2-85			Eckhart Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE			23e. NAME OF CEMETERY OR CREMATORY			23f. LOCATION CITY OR TOWN COUNTY STATE		
Eckhart-Allegany Co.-Maryland			Eckhart-Allegany Co.-Maryland			Eckhart-Allegany Co.-Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS			25a. DATE OF DEATH BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
George-Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, Maryland 21502			JUN 6 1985					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2 30 85 17 JAN

George Richard Clayton

Male

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20 20

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USA

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Allied

Cumberland

Sacked Heart Home

Norfolk Allied

Cumberland

x

14416 Winchester Rd.

218300082

yes

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR P M	
William		Gilbert		Clise				5		16		19		85		9:00	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	Feb. 23, 1919		66		YRS.				5		17		19		85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		USA		WIDOWED		DIVORCED		Allegany									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Near Eckhart		Piney Mountain		Electrician		Chessie											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Allegany		Cumberland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 5, Box 399 / 21502									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
William		Ellsworth		Clise		Mary		Alice		Blubaugh							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		WW II		214-05-5363		William J. Clise - Frostburg, MD											

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D.

MEDICAL EXAMINER

DATE SIGNED 5-17-85

EXAMINER'S NAME
(TYPE OR PRINT)

Francisco Reyes

ADDRESS

900 Seton Dr. Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

Burial

05/20/85

Rest Lawn Mem. Gard

LaVale, Allegany, MD

24. FUNERAL DIRECTOR
NAME

ADDRESS

John J. Hafer, Jr. LaVale, MD

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

MAY 22 1985

John Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 16 50M 4/83
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

1 2 8 0 6

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES G. COYLE			2a. DATE OF DEATH MONTH DAY YEAR 05 17 85		2b. HOUR 1:00 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 11 1901	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Charles Coyle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janet Preston		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-10-2462	17. INFORMANT ADDRESS Mrs. Carl Jonasha Westernport, Md. 21562		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe C.O.P.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Cholestasis & stone in common duct and Hepatocellular Jaundice</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-15</u> 19 <u>85</u> , to <u>5/17</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>5-15</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>V.A. Ranjithan</u>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. A. Ranjithan, M. D.				22e. ADDRESS LMNH, Seton Drive, Cumberland, MD 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/20/85		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Westernport Allegany Md.		24. FUNERAL DIRECTOR NAME <u>Boals Funeral Service</u> ADDRESS <u>Westernport, Md. 21562</u>			
25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randell</u>	

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 0 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Katherine Crowe		2a. DATE OF DEATH MONTH DAY YEAR 05 13 85		2b. HOUR M
3. SEX female	4. RACE cau.	5. DATE OF BIRTH MONTH DAY YEAR 05 14 08		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Alleg. MD.
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse	12b. KIND OF BUSINESS OR INDUSTRY Medicine
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Harry B. Klosterman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Helmstetter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -----		16b. SOCIAL SECURITY NO. 217-10-5477		17. INFORMANT ADDRESS Pauline Logsdon Ridgley, West VA
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSION</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>LT. PARIETAL GLIOBLASTOMA</u>				
19a. DATE OF OPERATION <u>NA</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NA</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>5-13</u> , 19 <u>85</u> , to <u>5-13</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>5-8</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Mohammad Shafiei, MD.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mohammad Shafiei		22e. ADDRESS Seton Drive, Cumberland, Md. 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/17/85	23c. NAME OF CEMETERY OR CREMATORY SS Peter and Pauls	
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD				
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home, Inc. 230 Baltimore Ave. Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR MAY 17 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 0 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William E Crowe			2a. DATE OF DEATH MONTH DAY YEAR 5/01/85		2b. HOUR 2:23a M		
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6/ 12/ 30		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany Co MD	
10. CITY OR TOWN OF DEATH Frostburg, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trackman		12b. KIND OF BUSINESS OR INDUSTRY Chessie System	
13a. STATE Md		13b. COUNTY Allegany		13c. CITY OR TOWN Lonaconing		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James A. Crowe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen L. Winner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean 726 18 9282	
17. INFORMANT Helen F. Crowe		18. ADDRESS 131 State Rt. Box 36 North, Lonaconing, Md		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>May 15, 1985</u> to <u>May 1, 1985</u> , that (I) (we) last saw the deceased alive on <u>May 15, 1985</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.		22b. SIGNATURE <u>Charles J. Orr</u> MD 22c. DATE SIGNED <u>May 2, 85</u>	
22a. SIGNATURE <u>Charles J. Orr</u>		22b. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. C. Orr		22c. ADDRESS 48 Tarn Terrace, Frostburg, Md		22d. DATE SIGNED <u>May 2, 85</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-3-85		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg Allegany Md	
24. FUNERAL DIRECTOR NAME Eichhorn		24b. DATE REC'D. BY REGISTRAR MAY 8 1985		24c. REGISTRAR'S SIGNATURE <u>John W. Rindell</u>		24d. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ AT WORK
NOT WHILE ☐ AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from May 15, 1985 to May 1, 1985, that (I) (we) last saw the deceased alive on May 15, 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR
NAME

24b. DATE REC'D. BY REGISTRAR

24c. REGISTRAR'S SIGNATURE

Eichhorn Funeral Home, Lonaconing, Md

MAY 8 1985

John W. Rindell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

134023



136012

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST THELMA	MIDDLE M.	LAST DAVIS	2a. DATE KNOWN OF DEATH ESTI. MONTH DAY YEAR MATED <input checked="" type="checkbox"/> 5 8 19 85		2b. HOUR M	
3. SEX Female	4. RACE cau	5. DATE OF BIRTH MONTH DAY YEAR 04-29-1922		6. AGE (IN YEARS) (LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 8 19 85	2d. HOUR 1330 M
7a. BIRTHPLACE (STATE OR COUNTY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 416 Goethe St				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY In Own Home
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 416 Goethe St. 21502		
14. FATHER'S NAME FIRST MIDDLE LAST Henry D. Waybright				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nanna Keplinger				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-80-9671		17. INFORMANT ADDRESS Mrs. Ora Lee Jackson, Cumberland, Daughter				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden
		DUE TO, OR AS A CONSEQUENCE OF Diabetes Mellitus		years
		(c)		years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

Obesity

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE <i>Paul Snow</i>	TITLE (SPECIFY) Asst dpty	MEDICAL EXAMINER	DATE SIGNED 5-8-85
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS		
Paul Snow, M.D.	Memorial Hospital		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-11-1985	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (CITY OR TOWN) COUNTY STATE Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR NAME James F. Scarpelli		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE MAY 14 1985 <i>John Davidson</i>	
ADDRESS Cumberland, Md. 21502		1	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

ONE



1000

158156

FOR STATE REGISTRATION
ROTRUCK FUNERAL HOME
85 S. MAIN STREET
KEYSER, WV 26726
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 1 0

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) HENRY EDGAR DENNIS			2a DATE OF DEATH MONTH DAY YEAR MAY 24, 1985		2b HOUR 7:30A M	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Jan 12 1935		6 AGE (IN YEARS LAST BIRTHDAY) 50 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD		
10 CITY OR TOWN OF DEATH Cumberland	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction		12b KIND OF BUSINESS OR INDUSTRY Self	
13a STATE Md	13b COUNTY Allegany	13c CITY OR TOWN Rawlings	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE Rt 3 Box 7X 21557		
14 FATHER'S NAME FIRST MIDDLE LAST Alvie		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Bunner		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (# YES, GIVE WAR OR DATES) No		
16b SOCIAL SECURITY NO. 236-50-2388		17 INFORMANT ADDRESS Rt 3 Box 7X Laura I. Dennis Rawlings, MD 21557				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Recent C.A.B. & Surgery.						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (if (this hospital) attended the deceased from 5-23 , 19 85 , to 5-24 , 19 85 , that (I) (we) last saw the deceased alive on 5-23 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE Clarence Vincent M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 5-24-85.
22d PHYSICIAN'S NAME (TYPE OR PRINT) CLARENCE VINCENT, M.D.		22e ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 5/26/85	23c NAME OF CEMETERY OR CREMATORY Potomac Memorial Gardens		23d LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral WV	
24 FUNERAL DIRECTOR NAME A. Craig Rotruck		85 ADDRESS S. Main St. Keyser, WV 26726		25a DATE REC'D. BY REGISTRAR MAY 29 1985		
				25b REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

158456

ROTHMAN REVENUE HOME
87 1/2 WARD STREET
KEYSER, VA 22720

MAY 20, 1982
EDGAR
HENRY

white
U.S.A.
ALLEGANY COUNTY

CLIMBERLAND
No
ALLEGANY
X
Box 7A
1557

Alvin
Dennis
275-50-2382
Dennis
Box 7A
1557

CLARENCE VINCENT, M.D.
900-B SETON DRIVE, CLIMBERLAND, MD 21802
Burial
5/25/82
Thomas Memorial Gardens, Keyser, Mineral VA
A. Main St.
Craig Rothman, Keyser, VA 22720

160046

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 1 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY ALBERTA DUDEK			2a. DATE OF DEATH MONTH DAY YEAR 05 27 85		2b. HOUR 1101 M	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12 28 05		6. AGE (IN YEARS LAST BIRTHDAY) 79	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Proprietor	12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE MD			13b. COUNTY ALLEG	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Thomas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Workman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-46-3219		17. INFORMANT ADDRESS Joseph W. Dudek, Same as 13c		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerotic Heart Disease		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Alzheimer's Disease			
19a. DATE OF OPERATION 5-27-85	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardiac Arrest	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-27-85 to 5-27-85 that (I) (we) lost saw the deceased alive on 5-27-85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Robustiano J. Barrera		DEGREE MD	22c. DATE SIGNED 5-29-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBUSTIANO J. BARRERA		22e. ADDRESS Mem. Hosp. Med Ctr., Cumberland, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 31 '85	23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR NAME ADDRESS Durst Funeral Home, Frostburg, Md.		25a. DATE REC'D. BY REGISTRAR 5-29-85	
		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

SECRETARY ALBERTA TOWER

RENAME WHITE 12 22 23

U.S.A. X

MEMORIAL HO. ALBERTA

ALICE 12 22 23

THOMAS

JOHN B. 12 22 23

COPIES ON FILE

ALBERTA TOWER
 12 22 23
 ALICE
 THOMAS
 JOHN B.

134016

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 3 1 2

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret L. Duncan			2a DATE OF DEATH MONTH DAY YEAR 4/27/85		2b HOUR 2:15a M
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 5/13/01	6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	# UNDER 1 YEAR MONTHS DATES # UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? United State	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10 CITY OR TOWN OF DEATH Frostburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a STATE Md			13b COUNTY Allegany	13c CITY OR TOWN Frostburg	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST William Whitehead			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Eisentrout		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212 74 4011	17 INFORMANT ADDRESS Lloyd L. Duncan Jr., Frostburg, Md. 56 W. College Ave.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal Failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Some GI Bleeding. Hepatic Failure</u>					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>April 18, 1985</u> to <u>April 27, 1985</u> , that (I) (we) last saw the deceased alive on <u>April 27, 1985</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Charles H. [Signature]</u>		DEGREE MD		22c DATE SIGNED 4/29/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. C. Oh		22e ADDRESS 48 Tarn Terrace, Frostburg, MD 21532			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Apr. 29, 1985	23c NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Frostburg, Allegany, Md.	
24 FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.		25 DATE REC'D BY REGISTRAR MAY 8 1985		26 REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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• 2

8 5 1 2 8 1 3

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
LORETTA		PEARL		DUNN				MAY 13, 1985								3:40P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.		9. MONTHS		10. DAYS		11. HOURS	
FEMALE		WHITE		12/20/06		78		YRS		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. ALLEGANY COUNTY, MD		11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12. KIND OF BUSINESS OR INDUSTRY		13. HOUSEWIFE		OWN HOME	
14. CITY OR TOWN OF DEATH		15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE IN HOME ADDRESS)		17. CITY OR TOWN		18. COUNTY		19. STATE		20. CITY OR TOWN		21. COUNTY		22. STATE	
CUMBERLAND		SACRED HEART HOSPITAL		FROSTBURG		ALLEGANY		MARYLAND		FROSTBURG		ALLEGANY		MARYLAND		FROSTBURG	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. INSIDE CITY LIMITS?		17. STREET ADDRESS / ZIP CODE		18. CITY OR TOWN		19. COUNTY		20. STATE		21. CITY OR TOWN		22. STATE	
ALBERT		MINNIE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		45 1/2 McCULLOH STREET		FROSTBURG		ALLEGANY		MARYLAND		FROSTBURG		ALLEGANY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		18. CITY OR TOWN		19. COUNTY		20. STATE		21. CITY OR TOWN		22. STATE	
NO		N.A.		232-50-8327		MR. HARRY DALE LANDIS, ECKHART, MD		FROSTBURG		ALLEGANY		MARYLAND		FROSTBURG		ALLEGANY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF (b)		21. DUE TO, OR AS A CONSEQUENCE OF (c)		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
Cardiac Arrest		Sudden Cardiac Arrest		Sudden Cardiac Arrest		Sudden Cardiac Arrest				PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21. YES <input type="checkbox"/> NO <input type="checkbox"/>		22. YES <input type="checkbox"/> NO <input type="checkbox"/>		23. YES <input type="checkbox"/> NO <input type="checkbox"/>		24. YES <input type="checkbox"/> NO <input type="checkbox"/>		25. YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and consistently filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked and Item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

3036A

PROSTATE, NO. 2139
60 W. MAIN STREET
SOMERS FUNERAL HOME

MAY 21 1985

Figure 2

ALLERSON COUNTY,

157054

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 ZIEGLER FUNERAL HOME
 HYNDMAN, PA. 15545
 CERTIFICATE OF DEATH

8 5 1 2 8 1 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN ALBERT ENSMINGER			2a. DATE OF DEATH MONTH DAY YEAR MAY 23, 1985		2b. HOUR 01:30_M		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 07/25/1910		6. AGE (IN YEARS LAST BIRTHDAY) YRS 74	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder		12b. KIND OF BUSINESS OR INDUSTRY coal mining	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Corriganville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Ensminger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melvia Gorsch		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 176-01-5051	
17. INFORMANT ADDRESS J. A. Ensminger, Jr., Box 164, Corriganville Maryland 21524		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2 Rt Lower lobe pneumonia DUE TO, OR AS A CONSEQUENCE OF 3 Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Severe CORD DUE TO, OR AS A CONSEQUENCE OF C. H. F		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 4-28 19 85 to 5-23 19 85 that (I) (we) last saw the deceased alive on 5-22 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-23-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. URIEL VELANDIA, M.D.		22e. ADDRESS 924 SETON DR., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/29/85		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Lavale, Allegany, MD	
24. FUNERAL DIRECTOR NAME Harvey H. Zeigler		ADDRESS Hyndman, PA 15545		25a. DATE REC'D. BY REGISTRAR MAY 28 1985		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

127024

SINGLES TOWNHALL HOME
HUNTER, PA. 15505



JOHN

SECRET

RECEIVED

MAY 26, 1955

01:30

ALLEGANY COUNTY

SACRED HEART HOSPITAL



176-01-5021

DR. URBAN WILKINS, M.D. 324 E. 10TH ST., PITTSBURGH, PA. 15202

176-01-5021

134015

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Jacob W. Evans			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 4/30/85		2b. HOUR MIN 8:30
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 12, 1907	6. AGE (IN YEARS) LAST BIRTHDAY 77 YRS.	IF UNDER 1 YR. MONTHS DAYS 77	IF UNDER 24 HRS. HOURS MIN 77
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 78 Grant Street	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Textile		12b. KIND OF BUSINESS OR INDUSTRY Celanese		13. STATE Maryland	
13a. COUNTY Allegany		13b. CITY OR TOWN Frostburg		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13d. STREET ADDRESS 78 Grant St., 21532		14. FATHER'S NAME FIRST MIDDLE LAST John Evans		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Fisher	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W. 2 217-10-6063		17. INFORMANT ADDRESS Helen S. Evans, Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Giovanni Mastzangelo</i>		TITLE (SPECIFY) <i>MD</i>		DATE SIGNED	
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastzangelo		ADDRESS 900 Seton Dr., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 2, 1985		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park Frostburg, Allegany, Md.	
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.		ADDRESS MAY 8 1985		25a. DATE REC'D. BY REGISTRAR <i>Julia Davidson-Randall</i>	
25b. REGISTRAR'S SIGNATURE					

141046

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 1 6

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH FELDSTEIN			2a. DATE OF DEATH MONTH DAY YEAR MAY 13, 1985		2b. HOUR P 11:40 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 17, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner/Operator-Retail Cloth.Store		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 684 Fayette Street / 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Oscar - Feldstein		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma - Gerson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 723-16-8834	17. INFORMANT ADDRESS Dorothy M. Feldstein-Address same as #13.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACTABLE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CORONARY Artery disease DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) S/P Myocardial infarction					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from 5/13/85 to 5/13/85 , that (b) (we) last saw the deceased alive on 5/13/85 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did not) view the body after death.					
22b. SIGNATURE Sherrill Miller		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Nathan		22e. ADDRESS Medical Building Memorial Hospital Cumberland, Md. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-15-85	23c. NAME OF CEMETERY OR CREMATORY Eastview Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland-Allegany Co.-Md.		
24. FUNERAL DIRECTOR NAME ADDRESS George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502			25a. DATE REC'D. BY REGISTRAR MAY 16 1985	25b. REGISTRAR'S SIGNATURE Gelia Davidson	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

2000.02.21.1

140053

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 1 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CARL NMI FERGUESON			2a. DATE OF DEATH MONTH DAY YEAR MAY 10, 1985		2b. HOUR 01:45A	
3. SEX Male	4. RACE WHT	5. DATE OF BIRTH MONTH DAY YEAR 10 12 05		6. AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Analyst		12b. KIND OF BUSINESS OR INDUSTRY Chemical

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Cumberland	13c. CITY OR TOWN La Vale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 106 West St. 21502
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Fergusson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle S. Emmett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	16b. SOCIAL SECURITY NO. 367-03-8946		17. INFORMANT ADDRESS Mrs. Doris Fergusson Same as #13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis Shock DUE TO, OR AS A CONSEQUENCE OF (b) Intestinal Obstruction ? Adh-Venous obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Severe ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Leucopenia (Post myocardial)**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	20c. HOW INJURY OCCURRED. (ENTER NATURE OF INJURY IN ITEM 21; (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 5/9/85 to 5/10/85 that (1) (we) last saw the deceased alive on 5/9/85 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE [Signature]	DEGREE	22c. DATE SIGNED 5/10/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RAUL V. FELIPA		22e. ADDRESS 925 BISHOP WALSH RD., CUMBERLAND, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 5/10/85	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
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24. FUNERAL DIRECTOR NAME Anatomy Board	ADDRESS Balto., Md.	25a. DATE REC'D. BY REGISTRAR MAY 15 1985	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

140023

CASE

DATE

PRESCRIPTION

MAY 10 1982

10-42A

ALLEGANY COUNTY

RECEIVED ALLEGANY COUNTY



1982-05-10

202 COTTON HIGH

CHIEF OF POLICE

DR. DAVID W. FELL

222 FISHON HILL RD., CUMMINGS, MD.

4135518

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 1 8

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH		2b. HOUR	
FIRST MARY		MONTH MAY 6TH, 1985		DAY YEAR 1;13 AM	
3. SEX FEMALE		4. RACE CAUCASION		5. DATE OF BIRTH	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. AGE (IN YEARS LAST BIRTHDAY) NINETY-ONE YRS.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
14. FATHER'S NAME FIRST MIDDLE LAST John Bartik		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Swack		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. 214-05-9305		17. INFORMANT ADDRESS MEMORIAL HOSPITAL		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES NO	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NO		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DR. NAGARATNAM RANJITHAN	
22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. NAGARATNAM RANJITHAN		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05-08-1985		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR MAY 10 1985	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	

135513

1:13 PM

MAY 01, 1995

FISHER

WASH

FEMALE

CAUCASIAN

12

19

30

WILSON

ALBANY COUNTY CORRECTION

MEMORIAL HOSPITAL

CUMBERLAND

MEMORIAL HOSPITAL

ST. JOSEPH'S

DR. HALLATON & ASSOCIATES

158088

Boals Funeral Home STATE OF MARYLAND
 1- FOR 111 Church Street DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 REGISTRAR Westernport, MD 21562 CERTIFICATE OF DEATH

85 12819

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Gerald Frantz			2a. DATE OF DEATH MONTH DAY YEAR May 27, 1985		2b. HOUR 12:05a			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 22 1920		6. AGE (IN YEARS, LAST BIRTHDAY) 65 YRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		
12b. KIND OF BUSINESS OR INDUSTRY Westvaco		13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 409 Spruce St. 21562		14. FATHER'S NAME FIRST MIDDLE LAST Wilbur Frantz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Myers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		16c. SOCIAL SECURITY NO. 220104835		17. INFORMANT ADDRESS Mrs. Edna Frantz Westernport, Md. 21562		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal cell carcinoma metastasis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) to lung, Cadaveria DUE TO, OR AS A CONSEQUENCE OF (c) Quies cirrhosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from May 14, 1985 to May 27, 1985 , that (I) (we) last saw the deceased alive on May 27, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Shin Kim, M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S ADDRESS (TYPE OR PRINT) Shin Kim, M.D.				22e. ADDRESS 90 Main St. Westernport, MD 21562				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/30/85		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westernport Allegany Md.		
24. FUNERAL DIRECTOR NAME Boals Funeral Service Westernport Md. 21562				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE JULIA DAVISON RUSSELL		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

173081

Boala Funeral Home
111 Church Street
Baltimore, MD 21202

10:02a

May 27, 1972

Frank

Gerard

Male

White

1:50

62

x

Portland

Albany County

Funeral

Boala Funeral Home

Boala

Albany

Funeral

x

May 27, 1972

Boala

Funeral

Boala

10:02a

May 27

Boala

Boala Funeral Home, 111 Church Street, Baltimore, MD 21202

80 Main St. Westport, MD 21152

John W. D.

Boala

Boala Funeral

Boala Funeral Home

Boala Funeral Home, 111 Church Street, Baltimore, MD 21202

129621

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 12820

1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Homer W Gardner			2a DATE OF DEATH MONTH DAY YEAR 5/01/85		2b HOUR 8:05a M				
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 5/27/23		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 61		7a IF UNDER 1 YEAR MONTHS DAYS 7b IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany Co MD			

10 CITY OR TOWN OF DEATH Frostburg, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Heavy Equipment Operator		12b KIND OF BUSINESS OR INDUSTRY or Doctor			
13a STATE Md		13b COUNTY Allegany		13c CITY OR TOWN Lonaconing		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 23 Charlestown St 21539	

14 FATHER'S NAME FIRST MIDDLE LAST Samuel Wilson Gardner		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Ravenscroft	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WWII		16b SOCIAL SECURITY NO 215 16 4198	
17 INFORMANT ADDRESS Mrs. Elva Gardner, Lonaconing, MD		23 Charlestown St.	

11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Renal Failure - Co PD Emphysema - Diabetes - Cirrhosis</u>			
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19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			

22a I certify that (I) (this hospital) attended the deceased from <u>4/25</u> 19 <u>85</u> , to <u>5/1</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>5/1</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
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22b SIGNATURE S. L. Sandhir MD		DEGREE		22c DATE SIGNED 5/1/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. L. Sandhir		22e ADDRESS 48 Tarn Terrace, Frostburg, MD 21532			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 5-4-1985		23c NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Lonaconing Allegany MD	
24 FUNERAL DIRECTOR NAME Eichhorn		24b ADDRESS MAIN ST.		25a DATE REC'D. BY REGISTRAR MAY 06 1985		25b REGISTRAR'S SIGNATURE John F. ...	

24c FUNERAL HOME Eichhorn Funeral Home		24d ADDRESS Lonaconing, MD		25c DATE REC'D. BY REGISTRAR MAY 06 1985		25d REGISTRAR'S SIGNATURE John F. ...	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 25M
(VRA 15, 4) 1/79

THE UNIVERSITY OF CHICAGO
LIBRARY

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "University" and "Library" are faintly visible.]

136016

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
James Harold Goss								5		9		85				0334 M	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS		IF UNDER 1 YR. HOURS MIN		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR			
Male	Cau	10 17 28		56 YRS.						5		9		85		0334 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
WV		USA				Allegany MD.											
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Cumberland		Memorial Hospital		retired steamfitter		Construction											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Allegany		Cumberland						14 C Jane Frazer Village							
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Elmer E. Goss		Hollie Lipscomb															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS											
yes		WW II		220-16-2622		Mrs. Mary R. Goss, Cumberland, MD - wife											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Ventricular fibrillation		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		1 hour									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		Chronic refractory arrhythmia		years											
		(c)		Arteriosclerotic heart disease		years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?													
Oct 1984		refractory arrhythmia- defibrillator insertion		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Paul Snow, M.D.		Memorial Hospital															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		05-13-1985		Restlawn Memorial Gard.		Cumberland Allegany MD											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
James F. Scarpelli, Cumberland, MD 21502				MAY 14 1985		Julia Davidson-Russell											

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

136016



[Faint handwritten signature or text]

YAN J. J. 1900

158072

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BESSIE M HENSEL			2a. DATE OF DEATH MONTH DAY YEAR May 28, 1985		2b. HOUR 12:25 P. M.	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 03-14-1897		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Winifred & Williams Road/21502	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Gilpin Lashley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Nycum			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 800-00-8755		17. INFORMANT ADDRESS Mrs. Doris Orndorff, Cumberland, MD-daughter		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) St Bleeding Thrombosis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/28/85 19 85 to 5/28/85 19 85 , that (I) (we) lost saw the deceased alive on 5/28/85 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Dr. Halmos		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/28/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Halmos		22e. ADDRESS Memorial Hospital Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05-31-1985	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		ADDRESS MD 21502		25. DATE REC'D BY REGISTRAR JUN 03 1985 REGISTRAR'S SIGNATURE John Davidson		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

123075

60% COTTON 14868

WELLMAN



135660

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 2 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANCIS R. HESS			2a. DATE OF DEATH MONTH DAY YEAR May 8, 1985		2b. HOUR 10:39 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 9 13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Textile	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Hess		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Twigg		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 217/10/4022	
17. INFORMANT Mr. John Hess		ADDRESS 12652 Grey Eagle Ct. Germantown, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UTI DUE TO, OR AS A CONSEQUENCE OF (c) Bladder neck constriction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. C. Merrick				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. H. C. Merrick				22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5/9/85		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR MAY 14 1985	
				25b. REGISTRAR'S SIGNATURE John T. ...			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CHARLTON ROAD

20% COTTON FIBERS



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

157040

STEWART FUNERAL HOME				STATE OF MARYLAND			
OAKLAND, MD 21550				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
EARL THORNTON HINEBAUGH				MAY 19, 1985			
1. SEX				2b. HOUR			
Male				8:50 A.M.			
3. RACE				5. DATE OF BIRTH			
White				MONTH DAY YEAR			
January 12, 1924				6. AGE (IN YEARS LAST BIRTHDAY)			
61 YRS.				IF UNDER 1 YEAR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
Maryland				USA			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
Cumberland				SACRED HEART HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Track Foreman				B & O Railroad			
13a. STREET ADDRESS / ZIP CODE				13b. INSIDE CITY LIMITS?			
511 E St. 21550				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
Earl Juber Hinebaugh				Minnie Wilfong			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
Yes				WW II 217 14 4401			
17. INFORMANT				ADDRESS			
Freda P. Hinebaugh, See #13 above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>4 months</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertensive hemorrhage</u>							
19a. DATE OF OPERATION <u>2/29/85</u> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Metastases</u> 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <u>March 1985</u> to <u>19 May 1985</u> , that (we) lost <u>18 May 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Frederick M. Miltenberger</u> DEGREE <u></u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED <u>19 May 85</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>FREDERICK MILTENBERGER, M.D.</u> 22e. ADDRESS <u>122 S. CENTRE STREET, CUMBERLAND, MD 21502</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u> 23b. DATE <u>5/22/85</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u> 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Deer Park, Garrett, Maryland</u>							
24. FUNERAL DIRECTOR NAME <u>Bradley A. Stewart</u> ADDRESS <u>Oakland, Maryland 21550</u> 25a. DATE REC'D. BY REGISTRAR <u>MAY 28 1985</u> 25b. REGISTRAR'S SIGNATURE <u>Frederick M. Miltenberger</u>							

DHMH - 16 60M 7/84
(VRA 15, 4)

127400



SACRED HEART HOSPITAL

MAY 20 1907

ALBANY COUNTY

MINERVA

ST. JOHN

PAID

MAY 20 1907

1:50 A.M.

FREDERICK WILSON, M.D.

122 S. CROWN ST., ALBANY, N.Y.

MAY 20 1907

160006

George-Upchurch FH
202 Green St
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REGISTERAR Cumberland, MD 21502 CERTIFICATE OF DEATH

8 5 1 2 8 2 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances Bell Hinzman			2a. DATE OF DEATH MONTH DAY YEAR May 31, 1985		2b. HOUR 5:37a	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 19, 1900		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.		
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		
14. FATHER'S NAME FIRST MIDDLE LAST Truman - Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan - (Unknown)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220165422		12b. KIND OF BUSINESS OR INDUSTRY Home		
17. INFORMANT Betty Hinzman-Address same as #13 above.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) As AD c Cardiac arrest, approx 15 min. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a CVA						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1976 to 5-31 , 19 85 , that (I) (we) last saw the deceased alive on 5-1 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
23a. SIGNATURE Wayne Spiggle, M.D.		DEGREE MD		22c. DATE SIGNED 6/3/85		
23b. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne Spiggle, M.D.		22e. ADDRESS BMG, 912 Seton Drive, Cumberland, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-3-85		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland-Allegany Co.-Md.		23e. DATE REC'D. BY REGISTRAR JUN 6 1985		23f. REGISTRAR'S SIGNATURE [Signature]		
24. FUNERAL DIRECTOR NAME ADDRESS George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

BP

150000

George Washington
203 Green St
Cumberland, MD 21502

Francis Bell
Lineman
May 21, 1988
2-378

Allegheny County,

Sacked Heart Hospital

3302 15423

Payne Spaulding, N.D.
Rt. 215
Caton Drive, Cumberland, MD

149110

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 12826

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LUTHER KENNETH HITE			2a. DATE OF DEATH May 18, 1985		2b. HOUR 11:03a _M
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 10 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital and Med. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired ABL	12b. KIND OF BUSINESS OR INDUSTRY explosives	
13a. STATE PA	13b. COUNTY Bedford	13c. CITY OR TOWN Rfd #3 Bedford	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rfd #3 Box #190, Bedford, PA 15522	
14. FATHER'S NAME FIRST MIDDLE LAST Charles I Hite		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 214-16-2289		17. INFORMANT ADDRESS Ruth Hite Rfd #3 Box #190, Bedford, PA 15522	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Bilateral pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <u>Severe COPD</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Left Cerebellar hemorrhage, Renal Failure, Carcinoma of the bladder</u>					
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE ANY DISSECTED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) attended the deceased from <u>5/18/85</u> to <u>5/18/85</u> , that (we) lost sight of the deceased after <u>5/18/85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>Shawn Mallon</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 20, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Nathan		22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 05-21-85	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME Silcox-Merritt F.H.		ADDRESS 21502 404 Decatur St., Cumb., MD		25. DATE REC'D. BY REGISTRAR MAY 24 1985	
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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2023 COLLECTION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and cemetery filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 27

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Delphia B Hyde			2a. DATE OF DEATH MONTH DAY YEAR 5/09/85		2b. HOUR 9:50am								
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 9/01/18		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany Co MD							
10 CITY OR TOWN OF DEATH Frostburg, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. STATE Md						13b. COUNTY Allegany		13c. CITY OR TOWN Midland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 51 21542	
14 FATHER'S NAME Robert						15. MOTHER'S MAIDEN NAME Mary		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17 INFORMANT Maxine L. Metts, Midland, Md.	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cordis Pulmonary Arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocardial Infarction</i>			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Jesus H-Ta Sr.</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 9, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Chong J. Tan				22e. ADDRESS Frostburg Plaza, Frostburg, Md			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-11-85		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d. LOCATION Frostburg Allegany Co MD	
24 FUNERAL DIRECTOR NAME George A. Eichorn				ADDRESS Main St. Eichorn Funeral Home, Lonaconing, Md.		25a. DATE REC'D. BY DEPT. OF HEALTH MAY 14 1985	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR P. 6:30 M.
ALBERT		LEE	JENKINS	May 11, 1985		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	White	09 19 1912		72 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Unknown	Unknown			Allegany MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland	Memorial Hospital					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE		
WV	Mineral	Fortashby		General Delivery 26719		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Unknown		Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
		218-03-1196		Medical Records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>to liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Probable Primary Carcinoma of Liver Severe COPD</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>5/11/85</u> to <u>5/14/85</u> that (1) (we) lost saw the deceased alive on above, (1) (we) did not view the body after death. 19 <u>85</u> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated		22b. SIGNATURE <u>Sham A. Nathan</u>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Nathan		22e. ADDRESS Memorial Hospital Med. Bldg., Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Removal		5-13-85	WVU Human Gift Registry		Morgantown, Monongalia, WV	
24. FUNERAL DIRECTOR NAME		25. DATE REC'D BY REGISTRAR		26. REGISTRAR'S SIGNATURE		
X Robert M. Chisholm		May 17 1985		John Burdon-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADA M (R) Joyce			2a. DATE OF DEATH MONTH DAY YEAR 5-10-85		2b. HOUR 11 08 AM
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 3 9 10	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cumberland Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired	12b. KIND OF BUSINESS OR INDUSTRY Fire Co.	
13a. STATE MD	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 506 Springdale Street/21502	
14. FATHER'S NAME FIRST MIDDLE LAST William Mason		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jesse Meehan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-0141	17. INFORMANT ADDRESS Mr. Paul Joyce, Cumberland, MD - husband		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) A.S.H.D. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: C.V.A. Chronic Renal failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/14 19 85 to 5/10 19 85, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE S.M. SHRESTHA		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.M. SHRESTHA		22e. ADDRESS The Memorial Hospital Cumberland, Md. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 05-13-1985	23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 15 1985			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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HAFER FUNERAL HOME
1- STATE 1302 NATIONAL HWY.
REGISTRAR LAVALLE, MD 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DOROTHY MAE KEISTER			2a. DATE OF DEATH MONTH DAY YEAR 5-31-85			2b. HOUR 1:37 A.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11-11-1927		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7c. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE W. Va.			13b. COUNTY Mineral		13c. CITY OR TOWN Ridgeley		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box 212 / 26753	
14. FATHER'S NAME FIRST MIDDLE LAST Paul Theodore Beckwith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Cecilia Shaffer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO 213245929		17. INFORMANT ADDRESS Harold T. Keister--same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Refractory C.H.F. & pulmonary</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CAD and MI's.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal Failure -</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> , 19 <u>85</u> , to <u>5-31</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>5-30</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Uriel Velandia</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) URIEL VELANDIA, M.D.						22e. ADDRESS 924 SETON DRIVE, CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 2, 1985		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial		23d. LOCATION CUMBERLAND, ALLEGANY, Md.			
24. FUNERAL DIRECTOR John J. Hafer, Jr 1302 National Highway						25a. DATE REC'D. BY REGISTRAR JUN 5 1985		25b. REGISTRAR'S SIGNATURE <u>Richard R. Riddle</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial receipt permit. Their pleases remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 show any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH 16-60M 7/84
(VRA 15, 4)

120041



MAHER FUNERAL HOME
1202 NATIONAL HWY.
LAVALE, MD 21032

DECEASED: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
ALLIANCE COUNTY



SACRED HEART HOSPITAL
BALTIMORE, MD
[illegible]
[illegible]
[illegible]

UPPER VIRGINIA, N.C.
224 SETON DRIVE, GREENSBORO, MD 21032

156122

GEORGE-UPCHURCH FUNERAL HOME STATE OF MARYLAND
202 GREENE STREET DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CUMBERLAND, MD 21502 CERTIFICATE OF DEATH

8 5 1 2 8 3 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LESLIE CLYDE KERNS			2a. DATE OF DEATH MONTH DAY YEAR MAY 28, 1985			2b. HOUR 8:35P M		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR February 16, 1907		
6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			8. CITIZEN OF WHAT COUNTRY? U.S.A.		
9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Potomac Electric Power Company			11. KIND OF BUSINESS OR INDUSTRY		
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland			12b. COUNTY Allegany			12c. CITY OR TOWN Cumberland		
13. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13a. STREET ADDRESS / ZIP CODE 11 S. Lee Street / 21502			14. FATHER'S NAME FIRST MIDDLE LAST William H. Kerns		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy Frances Armbruster			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 578-01-2505		
17. INFORMANT Marie Kerns-Address same as #13 above.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Lafarotomy for ruptured aneurysm 9 days DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION 5/21/85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Possible aneurysm			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. I certify that (I) (this hospital) attended the deceased from 5/21 19 85 to 5/28 19 85 , that (I) (we) last saw the deceased alive on 5/28 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE A. Sivan Pillai		
22c. DATE SIGNED 5/30/85			22d. PHYSICIAN'S NAME A. SIVAN PILLAI, M.D.			22e. ADDRESS 915 SETON DRIVE, CUMBERLAND, MD 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/1/85			23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland-Allegany- Maryland			24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A.			25a. DATE REC'D. BY REGISTRAR JUN 3 1985		
25b. REGISTRAR'S SIGNATURE [Signature]			25c. REGISTRAR'S NAME [Signature]			25d. REGISTRAR'S ADDRESS 202 Greene Street - Cumberland, Md. 21502		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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MAY 20, 1952

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ALLEGANY COUNTY

SACRED HEART HOSPITAL

570-07-2502



015 SEVEN THREE, CANTON, N.Y. 14502

A. SIMON FILIAL, INC.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARNGIE ASA KITZMILLER			2a. DATE OF DEATH MONTH DAY YEAR May 7, 1985		2b. HOUR 1:15 a.m.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept 27 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.Va	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner		12b. KIND OF BUSINESS OR INDUSTRY Coal	
13a. STATE Md.			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Wayne Kitzmiller			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Lewis Kitzmiller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-05-2211		17. INFORMANT ADDRESS David A. Burdock Kitzmiller, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>H. Merrick</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. H. Merrick				22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-9-85		23c. NAME OF CEMETERY OR CREMATORY IOOF Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Elk Garden Mineral W.Va
24. FUNERAL DIRECTOR NAME ADDRESS David A. Burdock Kitzmiller, Md				25. DATE RECD. BY REGISTRAR 26. REGISTRAR'S SIGNATURE MAY 16 1985 <i>John Burdock-Randall</i>		

MEDICAL CERTIFICATION

BP _____

DHMH - 16 60M 7/B4
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

140115



144067

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Blanche M. Lee			2a. DATE OF DEATH MONTH DAY YEAR 05 18 85		2b. HOUR 1:25 A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 08, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Queen City Towers/21502	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Weber		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Enos			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-05-4400	17. INFORMANT ADDRESS Mr. Brace E. Lee - Cumberland, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Chronic Congestive Heart Failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/12</u> , 19 <u>79</u> , to <u>5-18-85</u> , that (I) (we) last saw the deceased alive on <u>5-17</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>V. A. Ranjithan.</u>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. A. Ranjithan, M. D.		22e. ADDRESS LMNH - Seton Drive, Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 21, 1985	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Alleg., MD
24. FUNERAL DIRECTOR NAME William G. Kight		ADDRESS Cumberland, MD		25a. DATE REC'D. BY REGISTRAR MAY 22 1985	
		25b. REGISTRAR'S SIGNATURE <u>John F. ...</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

1-1007



Female	White	Sept. 08, 1891	93
Maryland	USA	x	
Cumberland	Lions Manor Nursing Home	Housewife	Own Home
Maryland	Allegany	x	Green Point \ 21505 503
Louis	Weber	Sara	Enos
No	Mr. Bruce E. Lee - Cumberland, MD		

William G. Right Cumberland, MD

Burial May 21, 1985 Hillcrest Burial Cumberland, Alleg., MD

143147

8 5 1 2 8 3 4

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORENCE M LIEBAU			2a. DATE OF DEATH MONTH DAY YEAR MAY 14, 1985		2b. HOUR A 4:15 M
3 SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 6 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND			13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST SIMON FULLER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORDIE KREIGER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-05-4559-8 213-74-4003		17. INFORMANT ADDRESS JOHN D. LIEBAU RFD 1 CUMBERLAND MD.	
18. CAUSE OF DEATH (Enter only one cause per line to be included in PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Arrest DUE TO, OR AS A CONSEQUENCE OF (b) CAD, COBD, Renal Dysfunction Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (c) ASCVD					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from May 13 1985 to May 14 1985 , that (I) (we) lost saw the deceased alive on May 13 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.					
22b. SIGNATURE Dr. Terry Williams		DEGREE MD		22c. DATE SIGNED 5-14-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Terry Williams		22e. ADDRESS Medical Building Memorial Hospital Cumberland, Md. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE MAY 16 1985	23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MD.	
24. FUNERAL DIRECTOR NAME STICOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.		4444		25a. DATE REC'D. BY REGISTRAR MAY 20 1985	
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

520

130533

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR						2a. DATE KNOWN OF DEATH		2b. DATE OF ESTI. MATED		2c. DATE PRONOUNCED DEAD	
1. DECEASED NAME (TYPE OR PRINT)						2d. DATE KNOWN OF DEATH		2e. DATE OF ESTI. MATED		2f. DATE PRONOUNCED DEAD	
Bucy Clary Liller						5 3 19 85		5 3 19 85		2:30 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		7. IF UNDER 24 HRS.	
M		W		Dec. 2, 1920		64 YRS.		MONTHS		DAYS	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				9. CITIZEN OF WHAT COUNTRY?				10. MARRIED			
W. Va.				U.S.A.				NEVER MARRIED			
11. CITY OR TOWN OF DEATH				12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Cumberland				Memorial Hospital				Letter Carrier			
14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				15. STATE				16. COUNTY			
W. Va.				Mineral				Burlington			
17. FATHER'S NAME				18. MOTHER'S MAIDEN NAME				19. ADDRESS			
Clary H. Liller				Amelia M. Adams				Rt 1 Box 19			
20. WAS DECEASED EVER IN U.S. ARMED FORCES?				21. SOCIAL SECURITY NO.				22. INFORMANT			
Yes				WW 11				236 20 9162			
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				24. IMMEDIATE CAUSE (a)				25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:				A.S.C.U.D.							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF							
				(b)							
				DUE TO, OR AS A CONSEQUENCE OF							
				(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				P.M. 19							
22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				22c. LOCATION			
								CITY OR TOWN COUNTY STATE			
22d. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
23a. ACTUAL SIGNATURE				23b. TITLE (SPECIFY)				23c. DATE SIGNED			
Francisco Reyes				Deputy				5-3-85			
23d. EXAMINER'S NAME (TYPE OR PRINT)				23e. ADDRESS				23f. REGISTRAR'S SIGNATURE			
Francisco Reyes				900 Seton Dr. Cumberland, Md.							
24a. BURIAL, CREMATION, REMOVAL (SPECIFY)				24b. DATE				24c. NAME OF CEMETERY OR CREMATORY			
Burial				6 May 1985				Philos Cemetery			
24d. LOCATION				24e. COUNTY				24f. STATE			
Westernport				Allegany				Md.			
25. FUNDING DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Allen Rotruck Keyser, W.VA.				MAY 7 1985							

DHMH-17
(VR A15 ME (5))

Dec. 2, 1950

Allegany

U.S.A.

W. Va.

Letter Carrier

at 1 box 19

Uniontown

W. Va. 26101

Allegany

Allegany

Uniontown

W. Va.

Uniontown, W. Va.

W. Va.

Yes

Allegany

Uniontown

W. Va.

Uniontown, W. Va.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1 - STATE
REGISTRAR

REG. NO.

158080

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE DEWEY LIVINGSTON			2a. DATE OF DEATH MONTH DAY YEAR May 26, 1985		2b. HOUR 11:34^a
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR AUG 24, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA. HOPEWELL	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BRAKEMAN		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD
13a. STATE PA.	13b. COUNTY BEDFORD	13c. CITY OR TOWN HOPEWELL	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE P.O. Box 26 / 16650	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES LIVINGSTON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BOLLMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 208-03-8773		17. INFORMANT (WIDOW) ADDRESS KATHRYN LIVINGSTON HOPEWELL, PA. 16650	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Severe Leukopenia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Left lower lobe Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Left lower lobe Pneumonia PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: COPD, CAD					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from 5/25/85 to 5/26/85 , that (b) (we) last saw the deceased alive on 5/26/85 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (f) (we) (did) (not) view the body after death.					
22b. SIGNATURE Shana Nakot		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Nathan		22e. ADDRESS Memorial Hospital Medical Building Memorial Ave., Cumberland, Md. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-28-85		23c. NAME OF CEMETERY OR CREMATORY REFORMED	
23d. LOCATION CITY OR TOWN COUNTY STATE YELLOW CREEK, BEDFORD PA.		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME GEORGE-URCHURCH F. H.		ADDRESS 202 GREENE ST. CUMBERLAND, MD.		25. REGISTRAR'S SIGNATURE John T. ...	

080021

160055

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 0 3 7

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Raymond Charles Logsdon			2a DATE OF DEATH MONTH DAY YEAR May 30, 1985		2b HOUR 7:10 PM	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR SEPT. 11 1914		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.		
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND			13b COUNTY ALLEGANY			
13c CITY OR TOWN CUMBERLAND			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST MICHAEL LOGSDON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH NICHOL			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW11		17 INFORMANT ADDRESS MRS LAWRENCE GRIFFITH 421 FURNACE STREET CUMBERLAND, MARYLAND 21502		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion & Infiltration		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Advanced Metastatic Carcinoma	
DUE TO, OR AS A CONSEQUENCE OF		(c) Prostate.	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO			
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19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			

22a I certify that (I) (this hospital) attended the deceased from 5/21 19 85 to 5/31 19 85 , that (I) (we) last saw the deceased 5/31 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death.					
22b SIGNATURE Walter N. Himmler, MD		DEGREE		22c DATE SIGNED 5/31/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Himmler		22e ADDRESS 500 Memorial Ave., Memorial Med. Bldg., Cumberland, MD 21502			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE JUNE 1 1985		23c NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MD.	
24 FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND, MD				25a DATE REC'D. BY REGISTRAR JUN 05 1985			
				25b REGISTRAR'S SIGNATURE G. A. Davidson			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

160002

200% COTTON FIBER

WELFARE DOWN



WELFARE DOWN

143024

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				2. DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
1302 National Hwy LaVale, MD 21502				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST William Brown Ludman				MONTH DAY YEAR May 17, 1985		HOUR 4:32am	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		MONTH DAY YEAR Dec. 21, 1899		75 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
OHIO		USA				Allegany County, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland		Sacred Heart Hospital		Ret. Accountant		Transportation	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE	
Maryland		Allegany		LaVale		6 Parkside Blvd./21502	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Henry W. Ludman				FIRST MIDDLE LAST Harriet Josselyn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes WW I				214056189		Mrs. Ruth Ludman - same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Cardiovascular arrest</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypotensive shock</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ruptured Aortic Aneurysm</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>G. Wagoner MD</i>				DEGREE		22c. DATE SIGNED	
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		5/17/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Gary Wagoner, M.D.				925 Bishop Walsh Road Cumberland, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		May 20, 1985		Sunset Mem.		Cumberland, Alleg., MD	
24. FUNERAL DIRECTOR NAME				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
John J. Hafer, Jr. LaVale, MD				MAY 20 1985 <i>John J. Hafer, Jr.</i>			

MEDICAL CERTIFICATION

1-10-52

Hager Funeral Home
1202 National Hwy
Lafayette, MD 21102

William Brown Ludman May 17, 1985 4:32a

Male

Dec. 27, 1909

62

Allegheny County,

OHIO

Sacred Heart Hospital

Cumberland

1000 E Parkside Blvd. V11802

Allegheny County

Teacher

Ludman

Henry

May 17, 1985 4:32a

312 Bishop Welsh Road Cumberland, MD

Gary Hager, M.D.

Allegheny County, Ohio, MD

May 20, 1985

Enlist

MAY 20 1985

John C. Hager, Jr. Lafayette, MD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 3 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HAROLD MARX			2a. DATE OF DEATH MONTH DAY YEAR May 22, 1985			2b. TIME 10:51 P. M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 3, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Jeweler		12b. KIND OF BUSINESS OR INDUSTRY Jewelry	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Growden Drive 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Marx			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Fine						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW11		17. INFORMANT Esther Marx, wife		same as 13a-e.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST - VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ACUTE ANTEROSEPTAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) COR. AR. - MYOCARDIAL FIBROSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes 8 DAYS - 1 YEAR?									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Rt + B.B.B. - ARTERIAL FIB - CARDIOGENIC SHOCK. AZOTEMIA -									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 80 to 5-22 , 19 85 , that (I) (we) last saw the deceased alive on 5-22-85 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) see the body after death.)									
22b. SIGNATURE <i>Samuel Jacobson</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-23-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Samuel Jacobson				22e. ADDRESS 50 Pershing Street Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/24/85		23c. NAME OF CEMETERY OR CREMATORY East View Cemetery Cumberland Allegany		23d. LOCATION CITY OR TOWN COUNTY STATE MD			
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home				25a. DATE REC'D. BY REGISTRAR (b) REGISTRAR'S SIGNATURE MAY 27 1985					
25b. ADDRESS 230 Baltimore Ave. Cumberland, MD 21502									

821001



1200: COTTON FIBER

CHIEF MAN

149093

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 4 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick T. Mc Kenzie			2a. DATE OF DEATH MONTH DAY YEAR May 18, 1985		2b. HOUR 12:30am		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 13, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 141 W. Main St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor		12b. KIND OF BUSINESS OR INDUSTRY Self Emp.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Mc Kenzie				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavina Machin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-09-6379		17. INFORMANT ADDRESS Mabel V. Mc. Kenzie, Same as 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>H. Merrick</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/20/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Curtiss H. Merrick, M.D.				22e. ADDRESS Mem. Hosp. Med. Bldg., Cumberland, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 20 '85		23c. NAME OF CEMETERY OR CREMATORY Johnson Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Garrett County, Md.	
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.				25a. DATE REC'D. BY REGISTRAR MAY 24 1985		25b. REGISTRAR'S SIGNATURE <i>John Frederick Randall</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

GEORGE

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135541

EICHORN FUNERAL HOME

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 4 1

1- FOR STATE REGISTRAR
MAIN STREET
LONA CONING, MD 21539

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH NMT METZ			2a. DATE OF DEATH MAY 5, 1985		2b. HOUR 11:25 A		
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 26, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) ILL.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Tire Builder		12b. KIND OF BUSINESS OR INDUSTRY Tire Co. Kelly Springfield	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Midland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Joseph		15. MOTHER'S MAIDEN NAME Stella		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219038701	
17. INFORMANT Florence Metz		18. ADDRESS Big Lane, Midland, MD.		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 15, 1985, to MAY 5, 1985, that (I) (we) last saw the deceased alive on MAY 5, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.							
22b. SIGNATURE Paul Livengood MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-6-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL T. LIVENGOOD MD		22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-7-1985		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d. LOCATION CITY OR TOWN COUNTY Frostburg Allegany MD	
24. FUNERAL DIRECTOR NAME Eichhorn Funeral Home		ADDRESS 8. East Main ST. Lonaconing, MD		25a. DATE REC'D. BY REGISTRAR MAY 10 1985		25b. REGISTRAR'S SIGNATURE Julia Livengood	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

1953-11

BIOGRAPHICAL
MAIN STREET
LAWSON, N. H.

1953-11

MAY 2, 1953

1953

1953

1953

ALLIANCE

SACRED TRUTH HOSPITAL

1953

ONE 610 SEVEN DRIVE, LEXINGTON, N. H.

157037

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 ! 2 8 4 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN ARNOLD MEYERS			2a. DATE OF DEATH MONTH DAY YEAR May 20, 1985		2b. HOUR 10:44 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-30-1920		
6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		
12b. KIND OF BUSINESS OR INDUSTRY Bailey-Meter		13a. STREET ADDRESS / ZIP CODE Rt. 1, Teets Rd., Friendsville, MD 21531				
13b. STATE Maryland		13c. CITY OR TOWN Friendsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Walter Meyers		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha V. Fearer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 175-14-1917		17. INFORMANT Geneviene Meyers		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Chronic Renal Failure, fluid overload, CHF.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE M-D		22c. DATE SIGNED 5/21/85		
22d. PHYSICIAN'S NAME (PRINT) Dr. Ranjithan		22e. ADDRESS 500 Memorial Ave., Memorial Medical Bldg., Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL Webb Chapel Cemetery		23b. DATE 5-23-1985		23c. NAME OF CEMETERY OR CREMATORY Friendsville, Garrett, MD		
23d. LOCATION CITY OR TOWN COUNTY STATE 155 Main St. Grantsville, MD 21536		24. FUNERAL DIRECTOR NAME ADDRESS Ruth K. Newman				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

10/10/61



UNITED STATES

FOR COTTON

148017

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 4 3

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Russell Lewis Minnicks			2a. DATE OF DEATH MONTH DAY YEAR May 18 1985			2b. HOUR 11 a.m.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 20 1915		6. AGE (IN YEARS (LAST BIRTHDAY)) 70 yrs		7. IF UNDER 1 YEAR MONTHS DAYS 70 yrs	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) P.P.G. & City of		12b. KIND OF BUSINESS OR INDUSTRY Cumberland	
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George - Minnicks			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel - Summers			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -			
16b. SOCIAL SECURITY NO. 214074836			17. INFORMANT Goldie S. Minnicks-Address same as #13.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Alzheimer's Dis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST			
19a. DATE OF OPERATION 5-18			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Alzheimer's Dis			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. I certify that (I) (this hospital) attended the deceased from 5-18 , 19 85 , to 5-18 , 19 85 , that (I) (we) lost saw the deceased alive on 5-18 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Victor Mazzocco DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22c. DATE SIGNED 5-19-85			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor Mazzocco, M.D.			22e. ADDRESS 912 Seton Drive - Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 5/21/85			23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Meml. Gns.			
23d. LOCATION CITY OR TOWN COUNTY STATE LaVale - Allegany - Md.			24. FUNERAL DIRECTOR NAME ADDRESS George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502			25a. DATE REC'D. BY REGISTRAR MAY 24 1985			
25b. REGISTRAR'S SIGNATURE Jane Davidson-Randall									

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

100017

100017

May 19 3 32 11 a.

Funeral Home

Male White 03 20 212 70 yrs

Cumberland Sacred Heart Hospital

214074832

Acute Cardiac Arrest

X

100017

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 3 4 4

136017

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BESSIE MONTELEONE		2a. DATE OF DEATH MONTH DAY YEAR May 8, 1985		2b. HOUR 10:50 P. M.	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 06-28-1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home
13a. STATE MD	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 206 Oak Street/21502	
14. FATHER'S NAME FIRST MIDDLE LAST James Mastrianni		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary LiCastro			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-46-2042		17. INFORMANT ADDRESS Mr. William F. Monteleone, Cumberland, MD-son	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>CAD</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Dr. H. C. Merrick</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. H. C. Merrick		22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 05-13-1985	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAY 14 1985	
				25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

130647

20% COLLION FIBER

CHALLENGER

AD-10



158172

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 4 5

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) CHESTER CAROL MOORE			2a DATE OF DEATH MONTH DAY YEAR May 24, 1985		2b HOUR 12:18 a.m.	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR MAY 28 1906		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Center		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
12a USUAL OCCUPATION (TYPE OF WORK, FOR MODEL OF WORKING LIFE) RETIRED CITY EMPLOYEE			12b. KIND OF BUSINESS OR INDUSTRY			
13a STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND	
14 FATHER'S NAME FIRST MIDDLE LAST FLOYD OSCAR MOORE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA SIMPSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 217-10-5841		17 INFORMANT VIOLA MOORE 213 MD. AVE. CUMBERLAND MD.	
18 CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>						
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u>						
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>5/28/85</u> to <u>6/24/85</u> that (we) lost saw the deceased alive on above (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>W. Guy Fiscus</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/24/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Guy Fiscus			22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 26 1985		23c. NAME OF CEMETERY OR CREMATORY TRINITY LUTH. CEMETERY		
24 FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL HOME CUMBERLAND, MD.		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MD.		25a. DATE REC'D. BY REGISTRAR MAY 28 1985		
25b. REGISTRAR'S SIGNATURE <u>John E. ...</u>						

128135

100% COTTON FIBER
CHIEFMAN



X

21/100

135528

BOAL FUNERAL HOME

WESTERNPORT, MD 21552

1- STATE REGISTRAR

21562

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 3 4 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN WILLIAM MOOREHEAD			2a. DATE OF DEATH MONTH DAY YEAR MAY 2, 1985		2b. HOUR 10:35 A
3. SEX Male	4. RACE White	5. DATE OF BIRTH 12 TH 25 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Westvaco
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Westernport	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George S. Moorehead		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Barrack			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-05-0266		17. INFORMANT ADDRESS Mrs. Marlene Ryan Westernport, Md. 21562	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Copd. acute exacerbate, & I bleeding</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>prostate cancer, BPH</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET) CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 14 1985</u> to <u>May 2 1985</u> , that (I) (we) lost saw the deceased alive on <u>May 2 1985</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. S. Kim</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. S. KIM, MD				22e. ADDRESS 90 MAIN STREET, WESTERNPORT, MD 21562	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/4/85	23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westernport Allegany Md.
24. FUNERAL DIRECTOR NAME Boals Funeral Service Westernport Md. 21562				25a. DATE REC'D. BY REGISTRAR MAY 10 1985	
25b. REGISTRAR'S SIGNATURE <u>John T. ...</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

158091

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 4 7

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAMIE RUTH MYERS			2a. DATE OF DEATH MAY 27, 1985		2b. HOUR 9:20 P M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 10/02/93		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY ALLEGANY		13c. CITY OR TOWN ELLERSLIE	
14. FATHER'S NAME LEWIS K. LOWERY			15. MOTHER'S MAIDEN NAME EMMA LOWERY (SAME) MN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-74-0807		17. INFORMANT HERBERT F. MYERS, BOX 54, ELLERSLIE, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrhythmia + failure, recurrent</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerotic coronary artery disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension + left ventricular failure</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>marked hypercarbia, pleural effusion, diabetes</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>5-13</i> , 19 <i>85</i> , to <i>5-27</i> , 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>5-27</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Richard Schindler</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>5-30-85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Richard E. Schindler				22e. ADDRESS 69 Greene St., Cumberland, MD 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE <i>5/31/85</i>		23c. NAME OF CEMETERY OR CREMATORY RESTLAWN MEM. GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE LA VALE, ALLEGANY, MD
24. FUNERAL HOME <i>Harvey H. Zeigler</i> HARVEY H. ZEIGLER, HYNDMAN, PA 15545				25a. DATE REC'D. BY REGISTRAR JUN 03 1985		
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodriguez</i>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 8 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)		2c. DATE PRONOUNCED DEAD		2d. HOUR	
THOMAS		May 4, 1985		5:00 AM	
3 SEX		4 RACE		5. DATE OF BIRTH	
MALE		WHITE		6/23/12	
6. AGE (IN YEARS)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
72 YRS.		MARYLAND		U.S.A.	
8 MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
NEVER MARRIED		ALLEGANY		FROSTBURG	
WIDOWED		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
DIVORCED		FROSTBURG COMMUNITY HOSPITAL		SUPV.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		ALLEGANY		FROSTBURG	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
ANTHONY		JOSEPHINE		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
213-03-0136		MRS. THOMAS NATOLLY, 91 W. MAIN ST.		PART I DEATH WAS CAUSED BY:	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		IMMEDIATE CAUSE (a)	
				Arteriosclerotic Heart Disease	
20. AUTOPSY?		21a. EXTERNAL CAUSE WAS		DUE TO, OR AS A CONSEQUENCE OF	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		(b)	
		21b. TIME OF INJURY		DUE TO, OR AS A CONSEQUENCE OF	
		HOUR A.M. MONTH DAY YEAR		(c)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>					
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					
22a. I certify that I took charge of the remains described above, held an		22b. TIME OF INJURY		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		HOUR A.M. MONTH DAY YEAR			
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		P.M. 19			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Giovanni Mastrangelo		Deputy		5/4/85	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL	
Giovanni Mastrangelo, M.D.		900 Seton Drive, Cumberland, Md		BURIAL	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
5/6/85		ST. MICHAEL CEMETERY		FROSTBURG ALLEGANY MD.	
23e. DATE RECD. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE		24. FUNERAL HOME	
MAY 8 1985				SOWERS FUNERAL HOME	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, AND 5 TO THE FUNERAL DIRECTOR. GIVE PAGES 1, 2, 3, 4, AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1000. GIVE PAGES 1, 2, 3, 4, AND 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

UNITED STATES

DEPARTMENT OF JUSTICE

ALBANY, N.Y.

TO THE ATTORNEY GENERAL

FROM THE DISTRICT ATTORNEY

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]



[illegible handwritten notes]

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FOR
STATE
REGISTRARLEASURE-STEIN F.H.
230 BALTIMORE AVE.
CUMBERLAND, MD 21502STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 3 4 9

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) DOROTHY SUSAN NOONAN		2a DATE OF DEATH MONTH DAY YEAR 05 11 85		2b HOUR 10:10^{AM}
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR May 4 1910		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.
10 CITY OR TOWN OF DEATH Cumberland	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laundry Worker	
12b KIND OF BUSINESS OR INDUSTRY Laundry				

13a STATE Maryland		13b COUNTY Allegany	13c CITY OR TOWN Cumberland	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 182 N. Centre St. 21502
14 FATHER'S NAME FIRST MIDDLE LAST James S. Kitzmiller			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary --- Simmons		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 214071472		17 INFORMANT Cumberland, Md. 21502 Mrs. Conrad Zimmermann Longwood Ave.	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary edema + severe		
DUE TO, OR AS A CONSEQUENCE OF (c) CORD		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b SIGNATURE GARY WAGONER MD	DEGREE M.D.
22c PHYSICIAN'S NAME (TYPE OR PRINT) GARY WAGONER, M.D.	22d ADDRESS 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE May 14, 85	23c NAME OF CEMETERY OR CREMATORY Restlawn Mem. Gardens LaVale	23d LOCATION CITY OR TOWN COUNTY STATE Allegany Md.
24 FUNERAL DIRECTOR NAME Cumberland Md. 21502		25a DATE REC'D. BY REGISTRAR MAY 17 1985	
25b REGISTRAR'S SIGNATURE Lelia Davidson-Randall			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

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MAY 1947

LEASING TIME H.
220 BALTIMORE AVE.
BALTIMORE, MD 21202

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202 PLEASANT VALLEY DRIVE, BALTIMORE, MD 21202

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is signed, any injury, or other traumatic event, the medical examiner must be called upon.

DHMH - 16 50M 4/83
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 ! 2 8 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace MAUDE Oglebay			2a. DATE OF DEATH MONTH DAY YEAR 05 02 85			2b. HOUR P M 7:00 P		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 25 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIONS MANOR NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY -----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD R. FRAME				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LIZA PENNY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-18-1375		17. INFORMANT ADDRESS CHARLES OGLEBAY 604 HILL ST. CUMBERLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory failure. DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma of the breast. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) (1) C.O.P.D (2) C.H.F. (3) Organic brain Syndrome								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4-15, 1985, to 5-2, 1985, that (I) (we) lost saw the deceased alive on 4-22, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE V. A. Ranjithan				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-3-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. A. Ranjithan, M. D.				22e. ADDRESS L.M.N.H. Seton Dr. Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 5, 1985		23c. NAME OF CEMETERY OR CREMATORY ZION MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MD.		
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.				25a. DATE REC'D. BY REGISTRAR MAY 06 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers		

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Imogene H. OSBOURNE</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5/6/85</i>		2b. HOUR <i>5 PM</i>
3. SEX <i>female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11-14-1905</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>79</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Allegany</i> MD.	
10. CITY OR TOWN OF DEATH <i>Cumberland</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cumberland Nursing Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>retired</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Ed of Education</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Allegany</i>	13c. CITY OR TOWN <i>Cumberland</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>112 Fourth Street/21502</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>John F. Whitney</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Phoebe Ellen Jamison</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>218-16-3924</i>		17. INFORMANT ADDRESS <i>Mrs. Frances Mc Gee, Cumberland, Md. Sister</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RESPIRATORY FAILURE.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>CARCINOMA OF LUNG.</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>May 5</i> , 19 <i>85</i> , to <i>May 6</i> , 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>May 5</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.					
22b. SIGNATURE <i>S. M. Shrestha</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>S. M. SHRESTHA</i>		22e. ADDRESS <i>THE MEMORIAL HOSPITAL Cumberland, Md. 21502</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>05-08-1985</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Burial Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cumberland Allegany MD</i>
24. FUNERAL DIRECTOR NAME <i>James F. Scarpelli, Cumberland, MD 21502</i>			25a. DATE REC'D. BY REGISTRAR <i>MAY 10 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John F. Scarpelli</i>

BP

STANDARD FORM NO. 64
MAY 1962 EDITION
GSA GEN. REG. NO. 27

1. *[Faint handwritten text]*

2. *[Faint handwritten text]*

3. *[Faint handwritten text]*

4. *[Faint handwritten text]*

5. *[Faint handwritten text]*

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. RETURN PAGES 1, 2, AND 3 TO THE FUNERAL HOME WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR					
JERRY			GEORGE PARKER			5-25-85			19			12:12					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
Male		White		5/13/1941		44 YRS.		MONTHS DAYS		HOURS MIN.		5-25-85		19		12:12	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland				USA				WIDOWED NEVER MARRIED DIVORCED				Allegany County					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland				The Memorial Hospital				Water Commissioner				Utility					
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. STREET ADDRESS					
WV				Morgan				Paw Paw				Winchester Street 99999					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.					
Delton				Parker				Pearl				Phillips					
17. INFORMANT				ADDRESS				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Cheryl Ann Kidwell, POBox 435, Paw Paw, WV								PART I DEATH WAS CAUSED BY:									
								IMMEDIATE CAUSE (a) Multiple injuries									
								DUE TO, OR AS A CONSEQUENCE OF									
								(b)									
								DUE TO, OR AS A CONSEQUENCE OF									
								(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													
20. AUTOPSY?				YES NO													
YES				NO													
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				11:25 AM 5-25-85				driver of motorcycle/pick-up truck impact									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
WHILE NOT WHILE AT WORK				hwy.				West bd. lane Rt. 51 Gorman Rd. Allegany Co., Maryland									
22a. I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and in my opinion																	
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
Margarita A. Korell, M.D.				Assistant, MEDICAL EXAMINER				5-26-85									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Margarita A. Korell, M.D.				111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				5/30/85				Camp Hill Cemetery				Paw Paw, Morgan, WV					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Helsley-Johnson FH. Berkeley Springs, WV				MAY 31 1985				Julia Davidson-Randall									

13136



13136

158113

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 5 3

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John E. Paupe			2a. DATE OF DEATH MONTH DAY YEAR 05-26-1985		2b. HOUR 1:30 A M						
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 02-01-1929		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 700 Holland Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Finance Co.			
13a. STATE MD						13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Paupe						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta Neff					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. Korean		17. INFORMANT Mrs. Mona Paupe, Cumberland, MD - wife		ADDRESS					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma Adrenal Gland</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 year</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>57</u> to <u>5/26</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>5/26</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William P. James</u>				DEGREE M.D.		22c. DATE SIGNED 5/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William P. James, M.D.				22e. ADDRESS 441 N. Centre St., Cumb., Md. 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05-28-1985		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR MAY 31 1985		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 5 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BONNIE LEE PLATT			2a. DATE OF DEATH MONTH DAY YEAR May 13, 1985		2b. HOUR 11:17 P.M.	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 05-11-1931		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Lester Thompson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maysell Dove		13e. STREET ADDRESS / ZIP CODE Route 4 - Mexico Farms/21502		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-26-9716		17. INFORMANT ADDRESS Mr. Richard K. Platt, Cumberland, MD - son		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEVERE COPD DUE TO, OR AS A CONSEQUENCE OF (c) EMPHYSEMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 75 MIN 10 YEARS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21a. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (EAT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (i) this hospital attended the deceased from 5/13/85 to 5/13/85 that (ii) (we) last saw the deceased alive on 5/13/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death, so state.)						
22b. SIGNATURE James F. Scarpelli		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/14/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James Raver		22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial		23b. DATE 05-17-1985		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				25a. DATE REGD. BY REGISTRAR MAY 17 1985		25b. REGISTRAR'S SIGNATURE [Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO: HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 27 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 8 5 5

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
SHARON MARIE PRYSOCK		Female		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
July 9, 1951		33 YRS		Allegany MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U.S.A.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Cumberland		Memorial Hospital		Registered Nurse	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
West Va.		Mineral		Ridgeley	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
William Lee Ward		Helen Marie Lease		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:	
218-60-1621		David Prysock - Address same as #13 above.		IMMEDIATE CAUSE (a) Cerebral Hemorrhage	
				DUE TO, OR AS A CONSEQUENCE OF	
				Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	
				DUE TO, OR AS A CONSEQUENCE OF	
				(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (c)					
Lupus Erythematosus; Ruptured Sigmoid.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-12, 1985, to 5-19, 1985, that (I) (we) lost		22b. SIGNATURE		22c. DATE SIGNED	
Dr. R. Barrera		Memorial Hospital Medical Building Cumberland, MD 21502		5-20-85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5-22-85		Sunset Memorial Park	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George-Upchuch Funeral Home, P.A. 202 Greene Street, Cumberland, MD. 215021		MAY 24 1985			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		26. HOUR	
BERTHA		LEONA		PULLIN				MAY 21 1985		8:15 A							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
FEMALE	WHITE	OCT 20 1902		82 YRS.						MAY 21 1985						9:00 A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
MARYLAND		USA		WIDOWED		DIVORCED		ALLEGANY									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY											
CUMBERLAND		220 BOND STREET		HOUSEWIFE													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MARYLAND		ALLEGANY		CUMBERLAND		YES		220 BOND STREET									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
JOHN		MARY		ELLEN		NICOL											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		212-12-8885		DONALD PULLIN		21 BEECHWOOD DRIVE											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				A-S.C.V.D.													
				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO									
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2											
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		P.M.		19													
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
WHILE AT WORK		NOT WHILE AT WORK		STREET, FACTORY, FARM, ETC.)		STREET											
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion									
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED									
EXAMINER'S NAME		ADDRESS															
Francisco Reyes		900 Sebn Dr. Cumberland Rd. 21502															
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
BURIAL		MAY 24 1985		HILLCREST BURIAL PARK		CUMBERLAND ALLEGANY MD.											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND, MD.		MAY 24 1985		Julia Davidson-Randall													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PAGE 5. FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M2/80

143002

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 5 /

156121

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Virginia		FIRST S.		MIDDLE S.		LAST RADCLIFFE		2a. DATE OF DEATH MONTH 5 DAY 20 YEAR 85		2b. HOUR 12⁵⁰ P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH November DAY 1 YEAR 1900		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS		# UNDER 1 YEAR MONTHS DAYS 		# UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegheny MD.					
10 CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Village Nursing Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pharmacist		12b. KIND OF BUSINESS OR INDUSTRY Medicine	
13a. STATE Maryland		13b. COUNTY Allegheny		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1 Kaylor Circle / 21532			
14. FATHER'S NAME FIRST Charles MIDDLE -- LAST Somerlatt				15. MOTHER'S MAIDEN NAME FIRST Louisa MIDDLE -- LAST Garten				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 214-05-4070				17 INFORMANT Joan Soisson				ADDRESS 68 Ridgewood Road Chagrin Falls, Ohio			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

(b)

acute Respiratory infection Poss

DUE TO, OR AS A CONSEQUENCE OF

(c)

Pneumonia

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Organic Brain Syndrome. Epilepsy. hypothyroidism. old age.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 19 80 to 5/22 19 85 , that (I) (we) lost saw the deceased alive on 5/15 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE S.L. Sandhir M.D.				DEGREE M.D.		22c. DATE SIGNED 5/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.L. Sandhir, M.D.				22e. ADDRESS Frostburg, Maryland 21532			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-24-85		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland-Allegany Co.-Md.	
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, Maryland 21502				25a. DATE REC'D. BY REGISTRAR JUN 3 1985		25b. REGISTRAR'S SIGNATURE S.L. Sandhir	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

128131



158149

SCHAEFFER FUNERAL HOME

STATE OF MARYLAND

8 5 1 2 8 5 8

1- FOR
STATE
REGISTRAR
PETERSBURG, WV 26847DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMITT REDMAN, JR			2a. DATE OF DEATH MONTH DAY YEAR MAY 21, 1985		2b. HOUR 8:35P M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10 15 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WVA		7b. CITIZEN OF WHAT COUNTRY? LISA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCM Allied EGRA BUSINESS		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE WVA		13b. COUNTY GRANT		13c. CITY OR TOWN Petersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Emmitt Redman SR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MYRTLE Redman		16. SOCIAL SECURITY NO. 232-26-1467		
17. INFORMANT NAME ADDRESS MABEL V. REDMAN - Petersburg WV		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Stomach DUE TO, OR AS A CONSEQUENCE OF (c) Simon				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-22-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. Schaeffer		22e. ADDRESS BMG-912 SETON DRIVE, CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-24-85		23c. NAME OF CEMETERY OR CREMATORY MALE Hill Cemetery		23d. LOCATION (CITY OR TOWN) COUNTY STATE Petersburg Grant WVA
24. FUNERAL DIRECTOR Blaine Schaeffer		DATE OF DEATH MAY 29 1985		REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

108113



WHITE

REDMAN, OR

MAY 21 1982

11:32P

BLACK

ALBANY COUNTY

SACRED HEART HOSPITAL

485-215 COLUMBIA DRIVE, ALBANY, NY 12202

143148

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 5 9

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret Elizabeth Reikie			2a. DATE OF DEATH MONTH DAY YEAR 05 / 14 / 1985		2b. HOUR 10⁴⁶ A.M.		
3. SEX female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 03 20 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 yrs	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		7b. CITIZEN OF WHAT COUNTRY? CANADA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD County	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY -----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FLINTSTONE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GORDON S. KILGOUR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH M. COGSWELL		13e. STREET ADDRESS / ZIP CODE RFD#1 BOX# 46 21530			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220480862		17. INFORMANT ADDRESS W. THORPE T. REIKIE RFD#1 FLINTSTONE MD.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Cardiac arrest*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) *Myocardial infarction*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Severe CAD*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: *no*

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Gary Waggoner</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary Waggoner		22e. ADDRESS 925 Bishop Walsh Drive, Cumberland, Md					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 17 1985		23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MD.	
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND, MD		ADDRESS		25. DATE RECD. BY REGISTRAR 26. REGISTRAR'S SIGNATURE MAY 20 1985 <i>John Davidson-Randall</i>			

BP _____
DHMH - 16 50M 4/83
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

43118

8

Margaret Elizabeth Felt

Female

03 20 1915

70 yrs

Alameda Co County

Boxed Heart Hospital

230480863

Gary K. Jones

925 Bishop Wain Drive, Cumberland, MD

140115

Scarpelli Funeral Home

STATE OF MARYLAND

8 5

1 2 8 6 0

FOR
1- STATE
REGISTRAR108 Virginia Ave
Cumberland, MD 21502DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Dorothy Alena Rexrode		2a DATE OF DEATH MONTH DAY YEAR May 11, 1985		2b HOUR 10:45p	
3 SEX female	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR 02-24-1928		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD	
10 CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b KIND OF BUSINESS OR INDUSTRY Garment factory
13a STATE WV		13b COUNTY Mineral	13c CITY OR TOWN Ridgeley	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Arthur Rexrode		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Bolton			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b SOCIAL SECURITY NO. 214-28-6333		17 INFORMANT ADDRESS Miss Thelma M. Rexrode-Ridgeley, WV Mrs. Ruth Harclerode-Hyndman, PA	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Amyleotrophic Lateral Sclerosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (i) (this hospital) attended the deceased from April 24 1985 to May 11 1985 that (i) (we) lost the deceased alive on May 10 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) use the body after death.					
22b SIGNATURE Paul J. Livengood MD		DEGREE MD		22c DATE SIGNED 5-13-85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Paul Livengood, M.D.		22e ADDRESS BMG, 912 Seton Drive, Cumberland, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 05-15-1985		23c NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery	
23d LOCATION CITY OR TOWN COUNTY STATE Fort Ashby Mineral WV					
24 FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502		25a DATE REC'D. BY REGISTRAR MAY 16 1985			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

7

40:45p

May 11, 1968

Bartholomew

James

Dorothy

Allegheny County,

Sacred Heart Hospital

214-22-2233

W. H. W. W. W. W.

Paul Thompson, M.D., 912 Foster Drive, Cumberland, MD

Paul Thompson, M.D.

157041

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Rotruck Funeral Home

STATE OF MARYLAND

FOR 85 S. Main St
1- STATE REGISTRAR Keyser, WV26767

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Judith Ann Reynolds			2a. DATE OF DEATH MONTH DAY YEAR May 21, 1985		2b. HOUR 12:04am	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 10 1940		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Alaska			13b. COUNTY North Star		13c. CITY OR TOWN Fairbanks	
14. FATHER'S NAME FIRST MIDDLE LAST Harry B. Ellifritz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Catlett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 234-62-4956		17. INFORMANT ADDRESS 148 Reynolds La. Fairbanks AK 99701		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanotic squamous cell carcinoma, primary unknown DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Gary Wagoner M.D.				22c. DATE SIGNED 5/21/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary Wagoner, M.D.				22e. ADDRESS 925 Bishop Walsh Road, Cumberland, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 24 1985		23c. NAME OF CEMETERY OR CREMATORY Potomac Memorial Gardens		
24. FUNERAL DIRECTOR NAME A. Craig Rotruck Keyser, WV 26726		25a. DATE REC'D. BY REGISTRAR MAY 28 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

127041



32 S. Main St
Keyser, West Va

English Ann

Reynolds

May 21, 1922

12:04am

female white

June 15 1910

Allegheny County

U.S.A.

Cumberland Sacred Heart Hospital

Homemaker

100 Reynolds Lane 29401

North Star Bank

Harry S. Elliff

29401

29401 Reynolds Ln.
Keyser, W. Va

X

Gary Henson, M.D.

225 Bishop Wain Road, Cumberland, W.

Burial

May 21 1922 Orono Memorial Gardens Keyser, Minn. W.

85 South Main Street

A. Craig Rothrock Keyser, W. Va 29401

Scarpelli
143142

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 6 2

1- FOR
STATE
REGISTER

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOMAN BRADFORD RILEY			2a DATE OF DEATH MONTH DAY YEAR May 15, 1985		2b HOUR:40 P.M.	
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 09-29-1924		
6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) announcer		12b KIND OF BUSINESS OR INDUSTRY radio		13a STREET ADDRESS / ZIP CODE 405 Caroline Street/21502		
14 FATHER'S NAME FIRST MIDDLE LAST Harry A. Riley, Sr.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Hartsaw		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		
16b SOCIAL SECURITY NO. 235-22-7396		17 INFORMANT Mrs. Beda M. Riley, Cumberland, MD - wife		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multi-system failure - liver, gallbladder, lung DUE TO, OR AS A CONSEQUENCE OF (b) Overwhelming septicemia - DUE TO, OR AS A CONSEQUENCE OF (c) Peritonitis		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cancer - left colon with pancreatic invasion						
19a DATE OF OPERATION 4/19/85		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer - colon		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) this hospital attended the deceased from 4/18 , 19 85 , to 5/15 , 19 85 that (we) lost saw the deceased alive on 5/15 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) did (I did not) view the body after death.						
22b SIGNATURE Thomas F. Lewis MD		22c DEGREE MD		22e. DATE SIGNED 5/16/85		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Thomas Lewis		22e ADDRESS Memorial Hospital Medical Bldg Cumberland, MD 21502				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 05-18-1985		23c NAME OF CEMETERY OR CREMATORY Rocky Gap VA Cemetery		
23d LOCATION CITY OR TOWN COUNTY STATE Flintstone Allegany MD		24 FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MAY 20 1985 REGISTRAR'S SIGNATURE

SECRET

CHIEF OF BUREAU

COPIES IN FILE



158014

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 3 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THELMA BERTHA RINGER			2a. DATE OF DEATH MONTH DAY YEAR May 26 1985		2b. HOUR 9:05 a
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR NOV. 1 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) W. VA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN MT SAVAGE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE RED# 1 BOX# 194 21545	
14. FATHER'S NAME FIRST MIDDLE LAST ROY VERNON GARLITZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA BERTHA MILLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO 218-24-8542		17. INFORMANT ALVA RINGER RED#1 MT SAVAGE, MD 21545	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 2 wk					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wk
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from 5-20-85 , 19 85 , to 5-26 , 19 85 , that (we) last saw the deceased alive on 5-25-85 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Anthony Bollino		DEGREE 2-2 ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 27/May/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Anthony Bollino		22e. ADDRESS 955 Frederick St., Cumberland, Md. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE MAY 29 1985	23c. NAME OF CEMETERY OR CREMATORY REST LAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE LAVALE ALLEGANY MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL HOME CUMBERLAND MD.		25a. DATE REC'D. BY REGISTRAR MAY 31 1985			
		25b. REGISTRAR'S SIGNATURE Julia Darden			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner should be notified.

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BOAL'S FUNERAL HOME
 1- STATE 111 CHURCH STREET
 REGISTERED WESTERNPORT, MD 21562
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ETHEL MAY ROBERTSON			2a. DATE OF DEATH MONTH DAY YEAR MAY 21, 1985		2b. HOUR 3:25P M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 7 1933		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nursing Home	12b. KIND OF BUSINESS OR INDUSTRY Nursing		
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Barton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Box 117 21521		
14. FATHER'S NAME FIRST MIDDLE LAST William Gardner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Shockry				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 220-30-7982	17. INFORMANT ADDRESS Mr. Charles Robertson Box 117 Barton, Md.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) — Metastatic oat cell ca. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — Diarrhea DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ASHD - coron. unperf.	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5-13-1985 to 5-21-1985, that (I) (we) last saw the deceased alive on 5-21-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.				
22b. SIGNATURE John Mehan	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5-21-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, M.D.		22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/25/85	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Barton Allegany Maryland
24. FUNERAL DIRECTOR NAME Boals Funeral Service Westernport, Md. 21562		25a. DATE REC'D. BY REGISTRAR MAY 24 1985	25b. REGISTRAR'S SIGNATURE J. L. ...

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DOAL'S FURNAL HOME
111 CHURCH STREET
WESTPORT, N.Y. 11862

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 6 5

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERVIN RICHARD SCHAIDT			2a. DATE OF DEATH MONTH DAY YEAR May 5, 1985		2b. HOUR 6:30 A.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 05-21-1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired carman		12b. KIND OF BUSINESS OR INDUSTRY railroad
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Oldtown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John H. Schaidt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Bell Furstenburg				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-12-4726		17. INFORMANT ADDRESS Mrs. Emma K. Schaidt, Oldtown, MD - wife		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4-7 19 85 to 5-5 19 85 that (I/we) lost saw the deceased alive on 5-3 19 85 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated.						
22b. SIGNATURE William Lamm		DEGREE MD		22c. DATE SIGNED 5-6-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William Lamm		22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05-08-1985		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		25a. DATE REC'D. BY REGISTRAR				
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25b. REGISTRAR'S SIGNATURE MAY 8 1985				

MEDICAL CERTIFICATION

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on page 1, it should be filed in the funeral director's file. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the funeral director. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECTION 13-1000

WATER



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

8 5 1 2 8 6 6

160026

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LOIS L SCHWAB			2a. DATE OF DEATH MONTH DAY YEAR MAY 29, 1985		2b. HOUR 12:36A.M.	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 02-18-1928		6. AGE (IN YEARS LAST BIRTHDAY) 57	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Head Designer		12b. KIND OF BUSINESS OR INDUSTRY Clothing	
13a. STATE MD	13b. COUNTY Allegany	13c. CITY OR TOWN LaVale	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 727 LaVale Terrace/21502		
14. FATHER'S NAME FIRST MIDDLE LAST Mark L. Lazarus, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Besse Kusner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 212-24-0892		17. INFORMANT ADDRESS Mr. Richard D. Schwab, LaVale, MD - husband		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADVANCED METASTATIC CA. BREAST DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (he) (she) (it) (did not) view the body after death						
22b. SIGNATURE <i>[Signature]</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/30/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Qamar Zaman		22e. ADDRESS Memorial Hospital Cumberland, Medical Building Maryland 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 05-31-1985	23c. NAME OF CEMETERY OR CREMATORY East View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR JUN 04 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it is a medical condition and should be signed at once.

ADVANCED RESEARCH IN PHYSICS
CENTRE FOR THE STUDY OF
THE FUNDAMENTALS OF MATTER



2/3/12

130531

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 6 7

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
CHARLES NORWOOD SEIBERT		5 1 85		2:52P M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
MALE	white	8 22 21	63	IF UNDER 24 HRS.	
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MD	USA		ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND	MEMORIAL HOSPITAL	retired	Tire Co.		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MARYLAND	ALLEGANY	CUMBERLAND	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	456 PENN AVENUE 21502	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)			
William R. Seibert		Clara O. Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
yes	WW II	Mrs. Eloise Seibert, Cumberland, MD-wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>cardio-pulmonary arrest</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) <u>severe chronic obstructive lung disease</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>ear pulmonary</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>pericarditis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION (CITY OR TOWN COUNTY STATE)			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Beck</u>		MD			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED	
Beck		Memorial Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN COUNTY STATE)		
Burial	05-04-1985	Sunset Memorial Park	Cumberland Allegany MD		
24. FUNERAL DIRECTOR (NAME ADDRESS)		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, MD 21502		MAY 7 1985 <u>John Seibert-Randall</u>			

130531

CHARLES HORNDOZ SERMENT

ALL

ELDERBURY COUNTY

CUMBERLAND MEMORIAL HOSPITAL

WILLIAM ALDERBURY CUMBERLAND
456 BEECH AVENUE 21503

151105

EICHORN FUNERAL HOME

STATE OF MARYLAND

8 5

1 2 8 6 8

1. MAIN STREET
FOR STATE REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

LONA CONING, MD 21539

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM WORKMAN SMITH			2a. DATE OF DEATH MONTH DAY YEAR MAY 21, 1985		2b. HOUR 3:45 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 17, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter		12b. KIND OF BUSINESS OR INDUSTRY Meat Dept.	
13a. STATE Md		13b. COUNTY Allegany		13c. CITY OR TOWN Lonaconing		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas R. Smith Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Lyons		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-05-6670	
17. INFORMANT ADDRESS Mrs. Nellie A. Woods, Lonaconing, Md		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GI bleeding</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ulcers? stress ulcer?</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Port of lap p. 80st.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION <u>5/12/85</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Acute abdomen - obstructed</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/21</u> , 19 <u>85</u> , to <u>5/21</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>5/21</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>G. B. Flores</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5/21/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR A. FLORES, MD		22e. ADDRESS 924 SETON DRIVE CUMBERLAND, MD 21502		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 23, 1985	
23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Moscow Allegany Md		24. FUNERAL DIRECTOR Eichhorn Funeral Home, Lonaconing, Md		25a. DATE REC'D. BY REGISTRAR MAY 27 1985	
25b. REGISTRAR'S SIGNATURE <u>J. B. Swickard</u>		25c. REGISTRAR'S SIGNATURE <u>J. B. Swickard</u>		25d. REGISTRAR'S SIGNATURE <u>J. B. Swickard</u>		25e. REGISTRAR'S SIGNATURE <u>J. B. Swickard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

151102

STOCK MARKET
MAIN STREET
LOANCOIN, MD 21152

WILLIAM KENNEDY SMITH MAY 21, 1983 2:05 A

ALBANY COUNTY

SACRED HEART HOSPITAL

CODE

DR. A. FLORES, MD DON STEIN DRIVE CUMMERS, MD 21152

130528

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 6 9

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIOLA MAE SPENCER			2a DATE OF DEATH MONTH DAY YEAR May 2, 1985		2b HOUR 9:10 ^{am}	
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 03-12-1912		
6 AGE (IN YEARS (LAST BIRTHDAY)) 73 YRS		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b CITIZEN OF WHAT COUNTRY? USA		10 CITY OR TOWN OF DEATH Cumberland		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b KIND OF BUSINESS OR INDUSTRY own home		
13a STATE WV		13b COUNTY Mineral		13c CITY OR TOWN Ridgeley		
14 FATHER'S NAME FIRST MIDDLE LAST Hampton Mosser		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Shaffer		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		
16b SOCIAL SECURITY NO. 214-05-4177		17 INFORMANT ADDRESS Mr. Robert L. Spencer, Ridgeley, WV - son Mrs. Deborah K. Golliday, Cumberland, MD				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Brain Stroke. DUE TO, OR AS A CONSEQUENCE OF (b) arterial Fibrillation, C.I. bleeding Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (d) Arterial Fibrillation						
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE K. Ashker		DEGREE MD		22c DATE SIGNED 5/2/85		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ashker		22e ADDRESS 500 Memorial Ave., Memorial Medical Building, Cumberland, MD 21502				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 05-05-1985		23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		
23d LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		24 FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				
25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE MAY 7 1985 Julia Davidson-Randall				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the Medical Examiner must be called on duty.



FOLLOW THE

WAVE



143111

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 7 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES JACOB SPERRY			2a. DATE OF DEATH MONTH DAY YEAR MAY 15, 1985		2b. HOUR 6:00 A.
3. SEX M	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11 27 85		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MINER	12b. KIND OF BUSINESS OR INDUSTRY COAL MINES	
13a. STATE PA			13b. COUNTY SOMERSET	13c. CITY OR TOWN SALISBURY	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST CLAY SPERRY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOSEPHINE BOLLINGER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 208-07-2723		17. INFORMANT ADDRESS CAROLYN SPERRY GRANT ST. SALISBURY, PA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (c) Renal Failure					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic Obstructive Pulm. Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital attended the deceased from May 12, 1985 to May 15, 1985 that (I) (we) last saw the deceased alive on May 12, 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE Chang Oh, MD		DEGREE MD		22c. DATE SIGNED 5-15-85	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) CHANG OH, MD		22f. ADDRESS 48 TARN TERRACE FROSTBURG, MD 21532			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/17/85	23c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE MEYERSDALE, SOMERSET, PA
24. FUNERAL DIRECTOR William R. Price II		325 MAIN ST ADDRESS MEYERSDALE PA		25. DATE REC'D. BY REGISTRAR MAY 21 1985	
				26. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1911



WILLIAM CHAPMAN

2017 NOTION 2017

CHAPMAN

JACOB

STEWART

MAY 12, 1908

1911

WILLIAM CHAPMAN

RECEIVED - CIVIL HOSPITAL

ONE OF THE

134535

DURST FUNERAL HOME
57 FROST AVENUE
FROSTBURG, MD. 21532

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 7 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GLENN NILE SPERRY			2a. DATE OF DEATH MONTH DAY YEAR MAY 1, 1985		2b. HOUR 04:20A M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 7, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Beer Co.	
13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Frostburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Sperry			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Howard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 2 215-20-5865		17. INFORMANT ADDRESS Pauline Sperry, Same as 13 e		
18. CAUSE OF DEATH (Enter only one cause per line) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure DUE TO, OR AS, CONSEQUENCE OF Advanced Squamous Ca of left palate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last one year DUE TO, OR AS, CONSEQUENCE OF metastasis one week						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) late Anterior septal Myocardial infarction						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) received the deceased from April 25, 1985 to May 1, 1985 , that (I) (we) last saw the deceased alive on May 1, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE Chang Oh, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 1-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. CHANG OH, M.D.			22e. ADDRESS 48 TARN TERRACE, FROSTBURG, MD. 21532			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 3, 1985	23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg, Allegany, Md.	
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE MAY 8 1985 [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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13-12-32

RECEIVED
ST. LOUIS, MO.
JANUARY 12, 1933

04-100

NOV 1, 1932

CHICAGO

MINN

CHICAGO

JAN 7, 1933

also

also

MINNAPOLIS

X

U.S.A.

MINNAPOLIS

RECEIVED

MINNAPOLIS

JAN 11, 1933

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 7 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bruce H. Stotler			2a. DATE OF DEATH MONTH DAY YEAR May 31, 1985			2b. HOUR 1:00 a. m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 14 04		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 527 Williams St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Clerk	
12b. KIND OF BUSINESS OR INDUSTRY Fiber Co.							
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 527 Williams St.		13f. CITY OR TOWN 21502					
14. FATHER'S NAME FIRST MIDDLE LAST Lee H. Stotler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude B. Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-07-5046		17. INFORMANT ADDRESS Magdalene Stotler, Cumberland, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 5 YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> NA		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA		21f. LOCATION STREET CITY OR TOWN COUNTY STATE NA			
22a. I certify that (I) (this hospital) attended the deceased from 6-14 19 48 , to 5-30 19 85 , that (I) (we) lost saw the deceased alive on 5-30 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. W. Ballin				DEGREE M.D.		22c. DATE SIGNED May 31, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph W. Ballin M. D.				22e. ADDRESS 51 Greene St., Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 31, 1985		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg Washington MD	
24. FUNERAL DIRECTOR NAME William G. Kight				ADDRESS Cumberland, MD 21502		25. DATE REC'D. BY REGISTRAR JUN 4 1985	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1:00 a. May 31, 1985 Stotler M. Prince

Male White

Allegany

Ret. Clerk 527 Williams St. Cumberland

MD Allegany Cumberland X 527 Williams St. 21502

Stotler B. Smith

214-07-5046 214-07-5046 Stotler, Cumberland, MD

May 31, 1985 xx

51 Greene St., Cumberland, MD 21502 Ralph W. Ballin M. D.

May 31, 1985 Smithsburg Crematory Washington

William G. Kight Cumberland, MD 21502

158020

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Joseph William Thomas			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5 27 85			2b. HOUR M 0925		
3. SEX Male	4. RACE Cau	5. DATE OF BIRTH MONTH DAY YEAR 05-16-1931	6. AGE (IN YEARS) (LAST BIRTHDAY) 54 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 27 85		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 535 Valley Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY unknown
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Thomas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret E. Miller			13e. STREET ADDRESS 535 Valley Street		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 227-34-9228		17. INFORMANT ADDRESS Mrs. Teresa E. Martin, Cumberland, MD			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Cardio-pulmonary arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b). Chronic lung disease		Years
(c).		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Hypertension

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion

ACTUAL SIGNATURE **Paul Snow** M.D. **Dpty** MEDICAL EXAMINER DATE SIGNED **5-27-85**
EXAMINER'S NAME (TYPE OR PRINT) **Paul Snow, M.D.** ADDRESS **Memorial Hospital**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 05-29-1985	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR MAY 31 1985	
		25b. REGISTRAR'S SIGNATURE John Davidson	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM JEM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Pierre N. Vallee			2a. DATE KNOWN OF DEATH ESTIMATED 05-14-1985		2b. HOUR 10:40 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 04-19-1904	6. AGE (IN YEARS) LAST BIRTHDAY 81 YRS.	IF UNDER 1 YR. MONTHS DAYS 19	IF UNDER 24 HRS. HOURS MIN. 19
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 5 / 21502		12b. KIND OF BUSINESS OR INDUSTRY Chemical	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Vallee			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgianna LaFrance		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 080-01-9426		17. INFORMANT ADDRESS N.Y. David Vallee - Wappingers Falls,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8129 IMMEDIATE CAUSE (a) RESPIRATORY FAILURE Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) MULTIPLE INJURIES (c) MOTOR VEHICLE ACCIDENT					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 Nov 4 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Two Car Accident	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Route 40, Road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Route 40, 1 Mile east of Frostburg Md Allegany	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i>		TITLE Deputy		DATE SIGNED 5-16-85	
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo		ADDRESS 900 Seton Drive Cumberland, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 17, 1985		23c. NAME OF CEMETERY OR CREMATORY St. Michael's Ceme Frostburg, Allegany, MD	
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.		ADDRESS LaVale, MD		25a. DATE REC'D. BY REGISTRAR MAY 20 1985	
		25b. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (1))
15M2/80

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MAY 20 1962

John J. Baker, Jr.

May 17, 1962

Enclosed

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1- FOR STATE REGISTRAR				7 5 1 2 8 7 5			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MONNA LEAFY WAMPLER				2a DATE OF DEATH MONTH DAY YEAR 05 04 85			
3 SEX FEMALE				7b HOUR 9:19P			
4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 04 05 15		6 AGE (IN YEARS LAST BIRTHDAY) 70		7a HOUR 9:19P	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7c CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY	
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a STATE MARYLAND		13b COUNTY Allegany		13c CITY OR TOWN OLDTOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Salem Elza		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maxie Jordan		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---		16b SOCIAL SECURITY NO. 215-34-4419	
17 INFORMANT Edward L. Wampler, Oldtown, MD		18 ADDRESS Rt. 1, Box 445		19 ZIP CODE 21555		20	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDINAL ARREST				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COPD - WITH				YEARS			
(c) CHP							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD - Severe							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 5/4/85 to 5/4 19 85 that (1) (we) lost saw the deceased (we) (did) (did not) see the body after death.				22b. DATE SIGNED 5/8/85			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James Raver				22d. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-8-85		23c. NAME OF CEMETERY OR CREMATORY Steele Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Friendsville, Garrett, MD	
24. FUNERAL DIRECTOR James Raver				25. DATE REC'D. BY REGISTRAR MAY 13 1985			
26. REGISTRAR'S SIGNATURE Julia Davidson-Randall				27. ADDRESS Grantsville, MD			

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ALLIANCE COUNTY

MEMORIAL HOSPITAL

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove confidential page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 7 6

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST Helen A. Warner		05-02-85		2:10 P.M.	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 12-21-1898		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cumberland Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) owner		12b. KIND OF BUSINESS OR INDUSTRY motel & restaurant
13a. STATE MD	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Route 8 Baltimore Pike 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Ryan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie (nmn)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215-20-5698		17. INFORMANT ADDRESS Mrs. Helen Auvil, Cumberland, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspirational pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CVA.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/12/85 to 5/12/85, that (I) (we) lost s/w the deceased alive on 5/12/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE H. H. H. H.		DEGREE MD		22c. DATE SIGNED 5/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P.B. HAZMOSS		22e. ADDRESS 302 Schlegel St. Cumberland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05-04-1985		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pk.	
				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR MAY 7 1985	
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

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Interference - 100%

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked gr, item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 1.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

SCARPELLI F.H.				STATE OF MARYLAND			
1- STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
108 VA. AVE CUMBERLAND, MD 21502				CERTIFICATE OF DEATH			
				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR			
EUGENE DOYLE WEBER				MAY 11, 1985			
3. SEX				4. RACE			
male				white			
5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			
Aug. 16, 1911				73 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
MD				USA			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
				ALLEGANY COUNTY MD			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
Cumberland				SACRED HEART HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
retired				Carpentry			
13a. STATE				13b. COUNTY			
MD				Allegany			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Cumberland				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Lewis F. Weber				Annie Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
yes				214-07-1822			
17. INFORMANT				ADDRESS			
Mr. Gene G. Weber, Cumberland, MD - son							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic carcinoma of brain</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PRIMARY UNK</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>G. Wagoner MD</u>				DEGREE		22c. DATE SIGNED	
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		5/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
DR. GARY L. WAGONER				925 BISHOP WALSH DRIVE, CUMBERLAND, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		05-14-1985		Sunset Memorial Park		Cumberland Allegany MD	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
NAME James F. Scarpelli, Cumberland, MD 21502				25b. REGISTRAR'S SIGNATURE			
				MAY 15 1985 <u>John Davidson-Randall</u>			

141078

STANDARD P.H.

108 VA. AVE.

CUMBERLAND, MD 21502

FUGITIVE DOYLE THREE MAY 11, 1968

END. 16, 1968

ALLIANCE COUNTY

SACRED HEART HOSPITAL

DR. GARY L. WOODNEY 225 21502 WITH 21502 CUMBERLAND, MD

143108

LECKEMBY FUNERAL HOME
FOR STATE 203 NORTH STREET
REGISTERED MEYERSDALE, PA 15552

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 7 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SAMUEL RALPH WEIMER		2a. DATE OF DEATH MONTH DAY YEAR MAY 11, 1985		2b. HOUR 1:50 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec 21 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Coal miner		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Pa	13b. COUNTY Somerset	13c. CITY OR TOWN Meyersdale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 307 Keystone St. 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Milton Weimer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Reese			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 211-01-2701	17. INFORMANT Rita Q. Weimer 307 Keystone St. Meyersdale, Pa. 15552			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) attended the deceased from <u>May 11, 1985</u> to <u>May 11, 1985</u> , that (ii) (we) last saw the deceased alive on <u>May 11, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not view the body after death, so state.)			
22b. SIGNATURE CHANG OH, MD.		22c. DATE SIGNED 5/12/85	22d. DEGREE MD
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS 48 TARN TERRACE, FROSTBURG, MD 21532	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/13/85	23c. NAME OF CEMETERY OR CREMATORY SS Philip & James	23d. LOCATION CITY OR TOWN COUNTY STATE Meyersdale Som. Pa.
24. FUNERAL DIRECTOR NAME M. Ray Leckemby		25a. DATE REC'D. BY REGISTRAR MAY 21 1985	
		25b. REGISTRAR'S SIGNATURE John Taylor	

143108

LEONARD RAYMOND
101 NORTH STREET
NEWCASTLE, PA 15802

SAMUEL RALPH MOTHER

11-02-1902

White

Dec 21 1902

ALLEGHANY COUNTY

SACRED HEART HOSPITAL

Religious Social Worker

Donor of Blood

307 North Street

Wilton Wilson

Donor

11-01-1902

No

Wife of

CLARK W. M.D.

11-01-1902

Donor of Blood

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 7 9

1 - FOR
 STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Paul Elmer Wenrich			2a. DATE OF DEATH MONTH DAY YEAR May 30, 1985		2b. HOUR A M 2:30 A
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APRIL 30 1906		6 AGE (IN YEARS (LAST BIRTHDAY)) 79 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIONS MANOR NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED CELENESE CORP. SILK		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 10 NORTH LIBERTY STREET	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE W. WENRICH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAMIE MARTIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW 11 214-07-4805		17. INFORMANT ADDRESS LAVALE, MARYLAND 21502 mrs james often 418 GEORGES CREEK BLVD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the colon & liver and Pulmonary metastasis. DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) (1) Diabetes Mellitus (2) L. sided. C.V. A.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4 - 18 , 19 85 , to 5 - 30 , 19 85 , that (I) (we) last saw the deceased alive on 5-29 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE V. A. Ranjithan		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/30/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. A. Ranjithan, M. D.		22e. ADDRESS LMNH, Seton Drive, Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 1 1985		23c. NAME OF CEMETERY OR CREMATORY ZION MEMORIAL PARK	
23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MD.		25a. DATE REC'D. BY REGISTRAR JUN 03 1985			
24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed in 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

158075

158072



20% COTTON FIBER

CHINA



158023

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 8 8 0

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVELYN MATILDA WILSON			2a DATE OF DEATH MONTH DAY YEAR May 26, 1985		2b HOUR 12:45 PM
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR NOV 20 1920		6 AGE (IN YEARS LAST BIRTHDAY) 64	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.	
10 CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		17a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		17b KIND OF BUSINESS OR INDUSTRY
13a STATE MD.		13b COUNTY ALLEGANY	13c CITY OR TOWN CUMBERLAND	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST ALBERT KALVUHN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HAZEL COCHRAN		13e STREET ADDRESS / ZIP CODE 232 NORTH CENTRE ST. 21502	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 219-03-8543		17 INFORMANT CAROLE KEISER PINTO, MARYLAND 21556	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sever failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic disease from</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Cancer of colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of colon</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION Feb 85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of colon		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. certify that (1) this hospital attended the deceased from <u>Feb</u> 19 <u>85</u> to <u>May 25</u> 19 <u>85</u> , that (2) (we) last saw the deceased alive on <u>May 25</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE Thomas J Lewis		DEGREE MD		22c. DATE SIGNED 5/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Thomas Lewis		22e ADDRESS Memorial Hospital Medical Building Memorial Ave., Cumberland, Md. 21502			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE MAY 29 1985		23c NAME OF CEMETERY OR CREMATORY HILLCREST CEMETERY	
23d LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MD.		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE MAY 31 1985 Julia Davidson-Randall			
24 FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL HOME CUMBERLAND MD					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death—page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or with 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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X

MAY 31 1982

160051

SCARPELLI FUNERAL HOME

STATE OF MARYLAND

8 5 1 2 8 8 1

1- FOR 108 VIRGINIA AVE.,
STATE REGISTRAR CUMBERLAND, M D 21502
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) LILLY PEARL WUNDERLICK			2a DATE OF DEATH MONTH DAY YEAR MAY 31, 1985		2b HOUR 6:30 P.M.	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Sept. 4, 1888		6 AGE (IN YEARS LAST BIRTHDAY) 96 YRS.	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD		
10 CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART= HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE MD		13b COUNTY Allegany	13c CITY OR TOWN Frostburg	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE Frostburg Village 21532	
14 FATHER'S NAME FIRST MIDDLE LAST John Riley Vaughn			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johnanna Hicks			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 193 36 9803		17 INFORMANT John Wunderlick Cumberland, MD		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) COLD- VESICAL FISTULA DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a						
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Sikander Sandhir</i>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/2/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIKANDER SANDHIR, MD		22e ADDRESS 48 TARN TERRACE, FROSTBURG, MD 21532				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6-3-85		23c NAME OF CEMETERY OR CREMATORY Altoona Fairview Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Altoona Blair Pa
24 SCARPELLI FUNERAL HOME Cumberland, MD 21502		25a DATE REC'D. BY REGISTRAR JUN 05 1985		25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>		

160021

SCOTT'S FURNACE HOME
108 VIRGINIA AVE.
GALVESTON, TEX. 77550

JULY PEARL WESTERLICK

MAY 21, 1962

1150 P

ALLEGANY COUNTY

SACRED HEART HOSPITAL

100% COTTON

IN THE OFFICE OF THE

SHAWNEE COUNTY